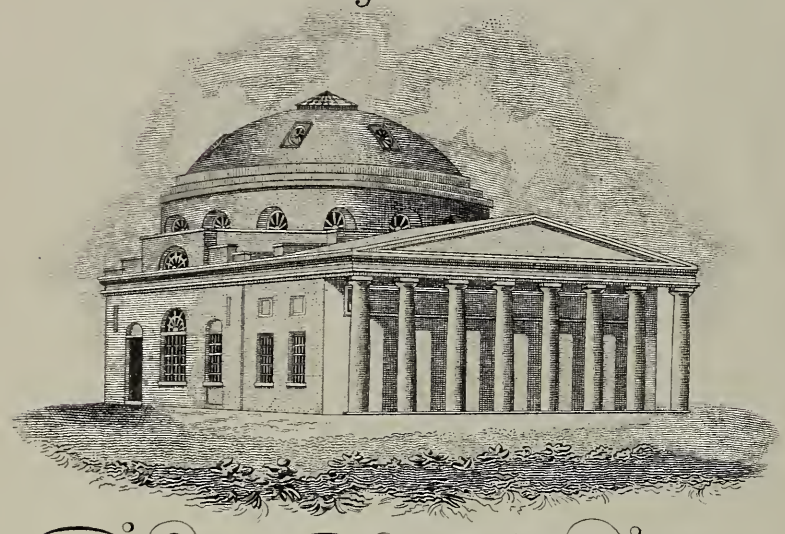
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The Role of Emergency Medical Service in Gas Defense

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GAS has not been used in this war in any widespread fashion or against any of our English speaking allies, even though the Japanese have employed it repeatedly against China, and Italy used it earlier against Ethiopia. We must never forget, however, that we are fighting a terrible, dangerous enemy who does not mean to lose this war and will use any means to achieve his end.

Pound for pound, high explosive is more destructive than war gas. Against the unenlightened, undisciplined, and unprotected population, however, the panic and confusion that gas warfare would produce might make its use eminently worth-while. Speculation as to what the enemy will do is dangerous and prediction has been largely futile. It is, after all, the enemy who will decide when and where he will use gas. We do know that he has technical equipment capable of bringing the war to this continent, and he could already have wreaked a certain amount of destruction on a few areas. It is quite probable that he has been deterred only by the immediate tightening of our own defenses that would result. He prefers that we be lulled into inaction until he is ready to loose a sudden massive attack which can have the maximum effect on our war effort. We must plan, and organize, and train; we must be ready.

Editor's Note

● As the war progresses, the probability that any substantial part of the civilian population of the United States will be exposed to gas warfare becomes more remote, although the possibility cannot be counted out entirely—especially with respect to coastal areas.

Nevertheless, the civilian population is constantly in potential danger of being exposed to war gas through explosions at plants where it is being manufactured or through wreckage of tank cars containing war gas being transported to supply depots.

Therefore, the medical profession, hospital administrators and others who would be expected to play a leading role in protecting and administering to the civilian population in event war gas should be let loose in a community, must be organized and trained to meet such an emergency.

The purpose of reproducing the accompanying article is to provide readers of *The Journal* with expert and authentic information on gas defense and the handling of casualties resulting from war gas.

CIVILIAN DEFENSE ORGANIZATION

The Office of Civilian Defense was established by the President to organize and mobilize the civilian population of the country in defense against total war. Working through State and local governments, a volunteer army of over five million civilians is being organized and trained to serve in the U. S. Citizens Defense Corps—after the Army and Navy, the third arm of our national defense. In fact, the British, under the stress of actual aerial attack, have found that

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the Civilian Defense organization is of equal importance with the military forces in defending the country and its people.

In order to work very closely with the Army in the present planning stage and in all future operating stages, the Office of Civilian Defense has established Regions coterminous with the Army Service Commands, with a field office in each. The national and regional staffs of the Office of Civilian Defense provide technical advice and assistance to State and local governments in all non-military phases of protection, including emergency medical service and gas defense. The Army looks to the Office of Civilian Defense to mobilize the civilian population in defense of the country in event of actual enemy attack and to co-ordinate the civilian effort with military needs.

Never forget, however, that the backbone of civilian defense is the local community and its own people and institutions, the police, the fire department, the hospitals, the doctors and nurses. Upon the excellence of the preparations in each community will depend the capacity of that community to care for its citizens in an emergency.

A PRACTICAL APPROACH TO THE GAS PROBLEM

In developing a sane approach to the problem of gas defense, we must realize first that if gas is used there will be casualties. Perfect protection is not possible, even for soldiers. Matériel shortages preclude the distribution of everything necessary to protect every individual in every situation to which he might possibly be exposed, even if it were possible to teach everyone how to use the equipment. Soldiers require hours of training and continued practice to maintain good gas discipline, but with the best training and equipment, casualties occur. Even a gas mask must be worn correctly, and it may prove an actual hazard to one unskilled in its use because of the false sense of security it may engender. Compare the problem of the disciplined soldier, who spends weeks learning to use his protective equipment, with that of the busy housewife, and you will realize that procedures and equipment required for her protection are different. *Avoid exposure; stay indoors; go to a previously prepared gas-tight room.* These are the keynotes of protection for the general population.

Physicians are in a particularly good position to lead in developing a sane attitude toward gas defense. It is important to recognize that gas defense is a quantitative problem and not an "all or none" phenomenon. Some hospital administrators have the idea that if one patient with a drop of mustard on him is admitted to a ward, all the personnel will be burned and all the patients will eventually die of bronchopneumonia. I know of three officers who were inspecting a tiny vial of mustard used for skin sensitivity tests. They accidentally spilled one drop which ran down the outside of the bottle. The odor of mustard soon became apparent in the room, and the group made a hasty exit. Then they sent a sergeant in to open a window!

This type of thinking must be changed. There are limits of tolerance, methods of improvising temporary protection, possible compromises, and simple, effective prophylaxis which permit us to protect ourselves if we understand the principles of gas defense. The concentration of gas in the air determines the intensity and rapidity of the effects produced. The lower the concentration, the longer is the period of exposure required to produce a casualty. We do not die from looking at a gas cloud 100 yards away.

If it becomes necessary as a result of fire or other destruction for inhabitants to leave their homes after a gas raid and be conducted through a contaminated area, safe lanes can be improvised by covering with planks, sand, sawdust, or in the winter, with snow. Overshoes, rubbers, or even old rags will protect shoes and feet for a time, while gloves and a rubberized or other overcoat or a skiing outfit will protect the hands and body. Any material covering will reduce exposure, and impervious garments such as cellophane capes, raincoats, and slickers will furnish considerable protection. Our goal is to minimize the effects of any exposure that may occur.

COMMUNITY ORGANIZATION

The problem of organizing and training a community for gas defense may be divided into three parts: 1. technical organization and training (non-medical); 2. medical, including protection of hospitals by cleansing stations; 3. education of the general public.

TECHNICAL ORGANIZATION

In a community the backbone of the technical organization for gas defense is the Senior Gas Officer. He is a qualified chemist, perhaps from industry. He is appointed by the defense council of the city government. He has been trained in a Gas Specialist Course in a War Department Civilian Protection School. These are schools established and operated by the War Department in collaboration with the Office of Civilian Defense to give instruction in certain technical phases of protection against enemy attack. The Gas Specialist Course includes instruction in the mode of action of chemical warfare agents and their detection in air, soil, food, and water in methods of decontamination, and in the organization of a community for gas defense. The Senior Gas Officer must be prepared to assist the police and fire departments, the wardens, and other emergency services including the Emergency Medical Service in the steps they must take if war gas is used.

He needs a staff of trained assistants—first and most important, the gas reconnaissance agents, who are trained and equipped to determine by chemical means the nature and extent of any war gas contamination. They are called upon frequently in England today because of the many unusual smells from refrigerants, explosives, and other agents spread about by the bombing. He will also need a laundry officer. Clothes are a serious problem. Some will have to be destroyed. Careful supervision of the decontamination of clothing is necessary to prevent unnecessary loss.

The actual decontamination of areas will be done by street cleaning departments and by the decontamination squads of the Citizens Defense Corps, but the Senior Gas Officer is the expert supervisor. He will also serve as technical consultant to the Chief of Emergency Medical Service.

MEDICAL ORGANIZATION

The training and organization of doctors and hospitals to care for gas casualties is the second consideration in preparing a community for gas defense.

The Chief of the Emergency Medical Service is responsible for the organization and emergency operation of all the medical facilities of the community. This includes seeing that physicians are instructed in the treatment of gas casualties and that hospitals are prepared to take the steps necessary to protect themselves and the hospital population against injury which might result from the admission of contaminated patients.

Every physician in the country should understand the mode of action of chemical agents and the treatment of gas casualties, even though his community may not be subject to attack. Physicians may be summoned from so-called "protected interior" locations to help care for an emergency on our target seacoasts.

The general principles are fairly simple, although many chemical warfare agents have been developed. More will be developed; old ones will be used in new ways or combinations; but the endless detail about each agent is not pertinent to our problem. There has been too much said about geraniums, apple blossoms, sour fruit, and garlic. The mass of pharmacologic and toxicologic detail is interesting but of little practical importance to the general practitioner.

We must think rather in terms of time; namely, persistent and non-persistent agents; and in terms of effects, the lung irritants, the skin and eye irritants, nose irritants, and the systemic poisons. There is some over-lapping between these groups. For example, skin irritants in sufficient quanity prove to be systemic poison or may even cause death from pulmonary effects. The usual effects from field concentrations, however, are indicated by the foregoing classifications.

With co-operation of the Committee on Treatment of Gas Causalties of the National Research Council, we have conducted special courses for instructors at selected medical schools over the country. These courses cover in some detail the chemistry, pathologic physiology, and pharmacology of the important agents and the treatment of injuries therefrom. The organization of the community for gas defense is described, and an outline syllabus of a 6-hour course of instruction for general practitioners is presented.

This 6-hour course presents in an empiric but rather complete fashion the essential information that will enable any physician to understand and to care for the ordinary gas casualty. Most medical schools have agreed to make available the services of their faculties to give this instruction to physicians, and the Emergency Medical Service in cooperation with medical societies is handling administrative arrangements, schedules, publicity, and the meeting of expenses. To secure geographic coverage, it is often necessary for a team of instructors to go out from the medical school to points over a state where physicians can congregate. In some cases the state has underwritten the expenses of the team, and in others, a local community has done so. The instruction may be conveniently given in three 2-hour evening sessions, although some communities have found it desirable to present the entire course on a Sunday when more of the doctors are free to come in.

GAS CLEANSING

Hospital administrators have special problems. They must plan for the provision of cleansing facilities for injured patients who are also contaminated. The early thinking was that public or mass cleansing facilities should be provided for the entire population, and the British proceeded to construct facilities on that basis. They now regret that they spent $50,000,000 on this program, and we all have come to recognize that it is quite impracticable. Liquid contamination must be removed within 5 minutes to prevent burns, and unless a cleansing facility could provide sufficient showers for every contaminated person in the neighborhood to bathe simultaneously, it would be ineffective and would only invite confusion and panic. Uninjured individuals must, therefore, cleanse themselves at the nearest house, while injured persons who are unable to cleanse themselves should be cleansed at facilities provided at hospitals. Of course, industrial plants which have large numbers of workmen on a shift must give thought to mass cleansing facilities, but that is a problem we will not go into here.

The term "cleansing" is reserved for human

beings; "decontamination" is applied to buildings, equipment, streets, and areas.

The principles of cleansing or decontamination are simple. Chlorination, oxidation, and hydrolysis are three important chemical processes which are available. Some agents are more susceptible to one process that to the others. Mustard, for example, is susceptible to chlorination and much less to hydrolysis or oxidation; Lewisite is quite susceptible to oxidation or hydrolysis; nitrogen mustards are susceptible to hydrolysis but not to chlorination. Accurate identification of the agents is necessary, therefore, before extensive decontamination of streets and areas can be efficiently carried out.

For human cleansing, however, the sodium hypochlorite bleaches combine oxidizing, chlorinating, and hydrolyzing effects, making indentification of the agent of less importance. Lacking bleach, a mild alkali, such as soap, sodium bicarbonate, or boric acid increases hydrolysis, Only mild solutions such as boric acid or sodium bicarbonate solution can be used in eyes and nose.

The persistent agents are oily liquids, but mechanical removal is of much value, even in the absence of neutralizing materials. Blotting off the excess and thorough washing with soap and water are effective on the human skin. Organic solvents may also be used to remove agents from the human skin, but great care must be exercised that in the process they do not spread the agent to new areas.

HOSPITALS

The hospital administrator must remember that his station is primarily for protection of his hospital. The time already elapsed makes it inevitable that most contaminated patients brought to his door will suffer burns. They must be cleansed primarily to protect the hospital and its personnel, and secondarily to minimize their own injuries from chemical agent.

The shortage of materials and the present state of the war make it inadvisable to construct new facilites for cleansing. The hospital must plan to adapt already available facilities, using a minimum of equipment, second hand if possible, to provide this service. In developing plans, the Medical Division of the Office of Civilian Defense has consulted with a number of hospitals, and in no case has it been impossible to find a suitable location that could be adapted quickly for cleansing purposes if necessary.

Certain principles may be set forth to indicate the type of plannng necessary. Three adjacent rooms or spaces are desirable, one for undressing, one for cleansing, and one for transfer of patients to clean stretchers before admission to the hospital. In the small hospital, however, two rooms or even one will suffice. The clothing may be removed out of doors if necessary, and the third room may be simply a hospital corridor sufficiently separated from the partly contaminated cleansing room.

It is important in plannng to remember that emergency resuscitation treatment must be available in or near the undressing room for gravely injured patients. These are patients with uncontrolled hemorrhages, avulsed limbs, etc., who might not survive the cleansing routine. They must be taken out of the line and given emergency treatment to control hemorrhage and relieve shock by the administration of morphine and plasma before they are cleansed. The personnel giving this treatment will, of course, need adequate protective clothing.

The gas cleansing unit must have a separate entrance which is away from regular ambulance entrances and vital parts of the hospital such as X-ray, operating rooms, kitchen, and laundry. If there is no door available, a window through which a stretcher can be passed may be used. A ramp may be constructed. The entrance should be located as close to a roadway as possible in order to eliminate stretcher carrying. Since a stretcher is 7½ feet long, stairways, sharp corners, and narrow corridors should be avoided.

The undressing and cleansing rooms must be equipped with functioning floor drains, floor grading which prevents spilling over into hallways and hot and cold water connections. The cleansing room must have two doors (or one door and window) through which cleansed patients may move out on the way to the hospital without backtracking. Thus recontamination can be avoided. Hydrotherapy rooms, and nurses' and interns' shower rooms are often found to be suitable, and in small hospitals, autopsy rooms.

Ventilation by an exhaust fan or large (20 inch) portable fan blowing out of the window is an important factor in undressing and treatment rooms. Bins must by provided in which to keep contaminated clothing. Shelves and cabinets are needed for supplies.

Space must be available so that patients can be transferred to clean stretchers. Since the patients are now clean, the corridor or any other space will do. A moveable rack for the soiled stretchers is essential, but caution must be exercised since they may be only partially decontaminated. From here the patient may go directly into the hospital and mingle with the other casualties.

An outdoor area adjacent to a steam hose outlet should be provided for the decontamination of stretchers. Each stretcher is to be decontaminated by brushing both sides with slurry of chloride of lime (3 shovelfuls in 2 gallons of water) to wash off the oily agent, then hosing with live steam. After stretchers have dried, they may be used again in ambulances going out.

In general, the size of the facilities set aside for gas cleansing purposes should be determined by the casualty receiving capacity of the hospital. For each stretcher station in the cleansing room, the estimated capacity is 10 patients per hour. If it is assumed that the bulk of casualties will be delivered within a 2-hour period and that 50 per cent will require gas cleansing, 3-stretcher capacity in the cleansing room would be needed for a hospital with casualty receiving capacity of 120 beds. This would care for 60 gassed casualties at the rate of 30 per hour with 10 for each stretcher station.

EDUCATION OF THE GENERAL PUBLIC

Education of the general public is the third and by far the most important part of the problem. Gas is a relatively impotent weapon against a trained population. Its effectiveness against civilians lies largely in its ability to cause panic rather than to cause casualties. It could be used effectively for this purpose by saboteurs.

Our objective in public instruction is to teach simple procedures which are the essence of protection, introducing a few technical details and leaving as little as possible to the judgment of the individual. The average citizen cannot be expected to identify agents accurately in an emergency, and he should be taught only such procedures as have the widest application.

The keynote of public instruction is self-aid. Gas attack by airplane spray or small bombs may expose many persons within a short space of time. When we remember that liquid vesicants must be removed within five minutes or less to avoid serious burns, it is apparent that uninjured persons will protect themselves more effectively by cleansing themselves at the nearest house, rather than delaying long enough to reach any public facility.

The official instructions issued by the Office of Civilian Defense on what to do in a gas attack are as follows:

1. *Stay indoors.* A tightly closed room affords protection against gas. All windows and doors should be tightly shut, and cardboard or blankets soaked with water should be kept in readiness to cover and seal shattered windows. Choose a room on an upper floor if possible; most war gases are heavier than air, although they may be carried up with air currents.

2. *If caught outdoors in a gas attack, get out of the area at once.* Look down and shield your eyes with your arm. Do not worry about any brief vapor exposure to which you may be subjected. The danger from this source is not great.

3. *Prompt action will avoid serious effects.* If you know or suspect that you have gotten any of the gas on your person or clothing, do not go hunting for a casualty station or gas cleansing station and expect someone else to help you. *Knock on the first door* you come to and do whatever is necessary for yourself. Self-aid is the quickest and safest way.

4. *This is what you should do. This routine should be memorized so it will be done automatically in an emergency.*

a. Remove shoes and outer clothing and drop them outside the house, in a covered can if available. Do not touch this clothing again except with sticks or gas-proof gloves. Do not cling to false modesty. To enter a house with contaminated clothing endangers everyone in it.

b. Get to a bathroom, kitchen or laundry room as fast as possible.

c. If your eyes have been exposed to liquid gas or spray, flush them immediately. Plain water out of a faucet, shower-head, canteen or douche bag will do, but a lukewarm dilute solution of bicarbonate of soda (heaping tablespoonful in a quart of water) is even better, if it is handy. Let anyone nearby help you.

d. If drops of liquid blister gas have splashed the skin, you can prevent serious burns by adequate cleansing. Promptly blot up the liquid with pieces of cleansing tissue, cloth or a handkerchief which should be disposed of carefully so that it cannot contaminate anyone else. Then sponge the skin briskly with laundry bleach containing sodium hypochloride, if it is at hand, and rinse off under the shower or in a tub. A thorough bath with a vigorous lathering is the final step, which should never be omitted. Dry the skin by patting. Do not rub. Dress in whatever clean clothing you can get. If blisters develop, you should seek medical advice.

e. If your nose and throat feel irritated, snuff and gargle with a dilute solution of bicarbonate of soda. If your chest feels heavy and oppressed, if you have any trouble breathing or if smoking becomes distasteful, lie down immediately and stay perfectly still until you can be taken to a doctor. Do this even if you feel fine otherwise.

5. *Remember: Cleanse yourself quickly and calmly. Follow the instructions of your air raid warden and wait until he tells you it is safe to come out.*

SUMMARY

1. The danger of gas attack on our civilian population is present, and our best defense is to plan, organize, and train.

2. The technical gas defense organization of the community must be established by the Senior Gas Officer under the U. S. Citizens Defense Corps.

3. The public must be educated in the principles of self-protection and self-aid.

4. Physicians should learn the principles of the mode of action of chemical warfare agents and treatment of gas casualties. Instruction is available through medical schools co-operating with the Emergency Medical Service.

5. Hospital administrators must plan to establish cleansing facilities for injured patients who are contaminated. Services of the Chief of Emergency Medical Service and the Senior Gas Officer are available to assist in such planning.

6. A sane approach to the gas defense problem will minimize the effects of any gas attacks that may occur.

A Country Doctor Diagnoses a Family

PAUL S. CRAIG, M.D., Washington C.H., Ohio

THIS Spring I stood at the edge of some broad ploughed acres which, for generations, have been famous for their tremendous productivity. Their owner remarked to me much as follows: "I do not understand it. Our family has raised hogs on this land for sixty years. We feed the same way we always did, water from the same spring, and operate on the same land, but the hogs I have been turning out lately sure are not the hogs we used to raise. They fatten slower, they never seem to get as big, and they are not the hogs my father used to brag about."

My friend is a practical farmer. He is honest, industrious, and intelligent. He is a good citizen, and never deliberately broke a law in his life; but he was totally unaware of the situation. In the first place, he did not know that ages before the Pyramids were built, Lake Erie covered this part of the country and had leached out the more soluble sodium salts, particularly the iodides, and they had long since been carried over Niagara and lost in the St. Lawrence. That was a serious handicap to begin with, fine for the goitre clinics, but tough on the rest of us. Then too, even as he looked at it, he did not realize that his fertile sloping corn field had been washed of most of its minerals, all of which by this time have long since been deposited in the Gulf of Mexico, and lost forever in the oceans of the world. And he knew he had not paid much attention to his fertilizer—this land was supposed to be eternal, also he could not afford it, every fence corner had to produce something to offset his crazy financial tangle. Now the indicator has swung to the left, it was on the discharge side, and he could read it in his hogs. Up to that time, no amount of argument could reach him.

But it would be expecting too much of him, or most of us, to see any possible connection between his tractor and the dental caries in his young grandson living a few miles away. The cause is too far removed from the effect for most of us to notice any connection. After my visit with him, I returned to town and read in the evening news that 49 per cent of our 20 year olds, who had been sent to Fort Hayes for examination have been returned home physically unfit. Perhaps the memory of the visit was too fresh in my mind, but somewhat the thought of inferior hogs became associated with the defective boys. To be sure, confections have chased a lot of fundamental nourishment from these boys, but was there enough in their food to begin with?

Anyway, it was a strange day in Fayette County, Ohio, probably as fine farming land as this country has, when we talked of second rate hogs and defective boys, after we had been taught to believe that of all places on earth, which are favorable to good living, this was the bonanza. Something very terrible has taken place, something very certainly has gone wrong.

It seems to me that what has happened is that the farmer's checking account on his land has finally run out. The drunken sailor on shore leave has been a very conservative fellow indeed in comparison to the American farmer and his land, and the rest of us have been suffering under the delusion that the farmer alone is the loser. There seems to be an erroneous notion that the great body of the earth is going to replenish the top soil as fast as we deplete it, but we should know by this time that it does not work that way; nature is generous, but not that generous.

The sequalae of impoverished land in Ohio are staggering, and the most serious ones have not yet appeared. It is bad enough to have the great financial companies own most of the county; to see so few owners living on their own land, and to have our best young men leave the land early in life for more lucrative fields, and the great incubator of citizenship fold up. It is pretty bad on us country fellows, even now, but another generation of nourishment from exhausted ground and the radius of regret will widen immensely.

How our people do expand with pride as they cite Valley Forge and Gettysburg, and many other exploits and sacrifices that our fathers endured to give us this land. And evidently the assumption is that it is our obligation to use it up as soon as possible. When we remark about the possibility of exhausting our natural resources, too many people solve the problem by the comforting assurance that they will be dead by that time! Unless this attitude changes, all the sacrifices of those superb founders of this country will be just a curious event in history, and when you read an advertisement for mineral and vitamin pills, and you are told they are indispensable to our welfare, it is not an advertisement at all ,it is a tragic indictment; it is a confession of calamity.

NOTE—One of a series of medical literary essays submitted at the request of The Editor.

Meningococcic Adrenal Purpura In Adults

HANS E. SIMMEL, M.D.*

FULMINATING purpura and extensive adrenal hemorrhage, occurring during the early stage of a septic toxemia has been described in about 100 cases, most of them in young children from two months to five years of age.[1] In 1901, Graham Little[2] recognized this clinical syndrome, describing four cases of his own and six observed by others, the first one in 1894 by Voelcker.[3] He did not find out which etiologic factor produced this rapidly fatal condition. In two of his cases numerous but unidentified cocci were present in cutaneous blood vessels. Andrewes[4] described in 1906 an isolated case of this syndrome in meningococcus septicemia. But neither Waterhouse[5] who collected about 15 cases in 1911 nor Friderichsen[6] who discussed 13 cases in 1918 could settle the etiologic problem. All authors agreed that the clinical picture was that of an overwhelming acute infection.

In 1916, MacLagan and Cooke[7] discovered the essential factor. To them the credit should be given for bringing this syndrome in line with a clinical morbid entity. In a publication covering only one page, the authors describe a group of meningococcus infection in young adults without meningitis but with severe purpura and hemorrhagic destruction of the adrenals. They also mention that an identical clinical picture may happen in septicemias of different etiology. Hemophilus influenza was found by Lindsay and his co-workers,[8] several pyogenic cocci by Firor,[9] Sacks,[1] and others. However, it has been proved in an ever increasing number of cases that this syndrome mostly results from a meningococcic bacteriemia and toxemia which kills the patient in 24 or 48 hours before definite clinical and anatomical signs of meningitis can develop.

Most of the cases listed as Waterhouse-Friderichsen Syndrome, adrenal apoplexy, etc., have been described in children. In adults, however, this clinical picture seems to be a rare one, at least it has been diagnosed only in a small number of cases. The syndrome has been found in young adults about 20 years of age, the first one in 1878 by Boureiff,[10] about 10 cases by MacLagan and Cooke[7] and a few ones afterward.

Two observations in slightly older patients are remarkable. The 27-year-old patient described by Carey[11] in 1940 is the only one who survived such an attack. The clinical picture was quite the same as in all the other cases; the patient apparently was saved by very early treatment with cortical extract and epinephrine, followed by antimeningococcus serum and sulfonamides. Gollick's[12] case, published in 1942, concerned a 32-year-old inmate of an asylum who was found dead in his bed one morning. The adrenal hemorrhage is described as "relatively recent" and "thrombi were noted in some of the veins of the capsule."

As far as I can see, only seven cases have been published in patients beyond 45. Aegerter[1]—three patients over 50; Andrewes[4]—a man of 53 (1906); Fahr[13]—a woman of 48 (1916); Rutishauser and Barbey[14]—a woman of 46 (1936); Kwedar[15]—a woman of 58 (1942). I am able to add the following observation:

Clinical notes (for which I am indebted to Drs. Mathias and Williamson—Niles, Ohio):

Mrs. L., 52 years of age, had had a mild head cold for several days; she, nevertheless, was able to do her housework. On 12-9-42 at 2 p.m., she went to bed having aches and pain over her entire body. About 4 p.m., she started vomiting. Pain in the extremities became more severe, vomiting was repeated several times. At 10 p.m., patient was seen by Dr. Mathias. Temp. 102; Pulse 115; Blood pressure 120/80. Patient was rational, but unusually tired. Skin normal. No marked diaphoresis. Right chest: possible beginning tubular breath sounds. Abdomen soft, no masses palpable, slight tenderness below the costal border on both sides. She was given ¼ gr. pheno-barbital and 10 gr. sodium salicylate.

At midnight, Dr. M. was called again. The family stated that the patient had broken out into a rash and was perspiring profusely. At 12:30 a.m.: Temp. 99; Pulse 120; B. P. 90/60. The body was covered with purpuric areas, chiefly over the face, lower abdomen, arms and thighs. The areas measured 2 mm. to 10 cm. in diameter. The patient had a purplish tint to her skin and was perspiring profusely. The extremities were cool and clammy. There was no external bleeding. Hospitalization was advised.

Physical examination: 12-10-42, 2:30 a.m. (Dr. Mathias.) The patient is an obese white female in critical condition, semiconscious. Temp. 99, pulse 100, respiration 20, blood pressure 60/0. The pupils react to light and accommodation. The conjunctivae show small purpuric spots as

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*Dr. Simmel died August 23, 1943, while on vacation at Colorado Springs, Colorado.

well as the mucous membranes of the mouth. The neck is normal, no rigidity present on flexion.

Heart: Normal in size, sounds distinct, pulse regular.

Lungs: Possible tubular breath sounds in the right lower lobe.

Abdomen: Slight tenderness across the upper abdomen. No spasticity, no rigidity. No masses palpable.

Liver and Spleen: Not palpable.

Reflexes: Physiological. No paralysis or limitation of motion.

Laboratory Findings:

Urine: Sp. gr. 1015. Albumen trace, no sugar. Few white blood cells, round epithelia and granular casts in the sediment.

Blood: Red cells 3,820,000; hemoglobin 11.5g% (70%); leukocytes 24,800; platelets 26,000; blood group AB (Moss 1).

Differential: Myelocytes 3%; juveniles 14%, stabs 22%, segmented neutrophils 52%, lymphocytes 8%, monocytes 1%. Toxic granulation is present and almost all cells except the lymphocytes show vacuolation. The platelets appear normal as to size and shape but are very scanty. The red cells show slight polychromia; four normoblasts per 100 white blood cells were found. No bacteria could be seen on the smear.

Despite treatment with analeptics patient expired at 12:15 p.m., 22 hours after the onset of clinical symptoms and 12 hours after the outbreak of the purpura.

POST MORTEM EXAMINATION

The post mortem, done two hours after death, showed:

Well developed, well nourished white female.

Very extensive cutaneous hemorrhages are present on face, neck, trunk and extremities. Some are small, many measure up to 10 cm. in diameter. In the abdominal fat tissue which measures 3 cm. in thickness many pale red extensive hemorrhages are to be seen. Hemorrhages measuring up to 8 mm. in diameter are scattered over the peritoneum of the small intestine, the sigmoid and the mesentery. Extensive parametric adhesions are present.

The axillary lymphnodes are enlarged, pink in color.

No thymus tissue found microscopically.

Heart: 240 gm. Very small hemorrhages on the epicardium. Otherwise no abnormalities.

Lungs: Slightly emphysematous, some old pleural adhesions.

Spleen: 140 gm.; 11:8:4 cm. Section surface dark red; follicles and trabecules visible; pulpa does not scrape.

Liver: 1470 gm. Color red brown. Near the lower edge a few small hemorrhages are present. Lobulation barely visible.

Adrenals: Both are in normal positions and embedded in abundant fat tissue. The organs appear dark red; no hemorrhages present in the surrounding tissue. No thromboses were found in the adrenal veins. The right adrenal weighs 6 gms. and measures 58:32:8 mm. It is of normal shape. The color is dark bluish red. On cross section a normal distribution of cortex and medulla is present. The latter is gray but the cortex is dark red almost throughout. It contains only small scattered yellow areas. The left adrenal weighs 7 gms. and measures 45:30:11 mm. The shape is normal, the color is dark. On cross section it is dark red; the pattern is barely visible. On some sections small amounts of yellow cortical lipoids and of gray medulla are visible. The consistency of the organs is normal. No cysts with blood or blood clots are visible.

Kidneys: 250 gm. together. Veins of surface congested. Small hemorrhages in the left kidney pelvis. Otherwise no essential findings. Ureter n.a. Bladder empty.

Uterus: Contains a node measuring 5 cm. in diameter (fibromyoma). Small hemorrhages present in the endometrium.

Ovaries: Small.

Stomach: Markedly distended with gas and liquid contents.

Small intestine almost completely empty and tightly contracted. Peyers patches and mesenteric lymphnodes not enlarged.

Colon: Contains brown stools. About 20 hemorrhages measuring 2-3 mm. in diameter are present in the mucosa of the cecum.

Pancreas: n.a.

Scalp and skull show no abnormalities. Dura firmly adherent to the bone. On the posterior surface of the right os petrosum epidural hemorrhage measuring 1 cm. in diameter is present. Sinus durae n.a. The pia is slightly opaque in places but no exudate is to be seen microscopically.

Brain: 1360 gm. Ventricular system not distended, contents clear. No hemorrhages.

The main microscopical findings were:

Spleen: Follicles small. Edema and some hemorrhages present. The sinus contain neutrophilic and a few eosinophilic leucocytes. Diagnosis: Acute splenitis.

Axillary Lymphnodes: Edema. The reticuloendothelium is hyperplastic and shedding.

Diagnosis: Acute lymphadenitis.

Liver: Small foci of chronic interstitial hepatitis are present. The organ is rich in fats.

Pancreas: n.a.

Coecum: Hemorrhages and hemorrhagic erosion.

Adrenal: The cortex is filled with widespread hemorrhages. In some areas the capillaries are distended with blood and extravasation is seen along them but in many places it is quite diffuse resulting in a patchy destruction of the cortex. In places edema is present around the cortical cells and some of the cells appear hydropic but most of them are normal in size, shape and structure. They are rich in lipoids throughout (Nile-blue stain). In several places showing no hemorrhage small accumulations of polymorphonuclear leukocytes are present.

In the medulla marked edema and smaller hemorrhages present. A fairly large and some small areas showing intensive infiltration with lymphocytes are to be seen. No thrombi were found in the blood vessels.

Diagnosis: Capillary hemorrhages, mainly in the cortex.

Kidney: Cloudy swelling. Capillary hemorrhages.

Skin: The small blood vessels and especially the capillaries of the corium are distended with blood and red blood cells are found in the pericapillary lymph spaces. Diffuse hemorrhage is also present. No bacteria were found.

Diagnosis: Capillary hemorrhages.

Bone Marrow: (Sternum) Megakaryocytes frequent. Myeloblasts and myelocytes n.a. Normoblasts in average number.

Brain: In all sections, taken from nine different areas the blood vessels are markedly distended; occasionally red blood cells are to be seen in the perivascular lymph spaces but otherwise no hemorrhages are present. In the pia above the parietal and temporal lobe, cerebellum and pons the blood vessels are distended with blood.

A cell rich exudate is present consisting of neutrophilic and a few eosinophilic leukocytes and round cells, lymphocytes, macrophages, which have engulfed granules of pigment, and shedding endothelia of the leptomeninx. Near the surface and deep in the sulci of the hemispheres and of the cerebellum gramnegative diplococci having the shape of meningococci are present. They are found extracellular and in leukocytes, occasionally in other cells. The gray and white matter of the brain and its inner surface (lateral ventricle, aquaeductus) show no abnormalities in structure.

Diagnosis: Early meningococci meningitis. Hyperemia of brain.

This condition, so far, has been known as occurring mainly in young children. It is a well established fact that the victims of cerebrospinal fever in epidemics and in sporadic cases are mostly children. Another exposed group are young men of military age and among those we find again cases of rapid breakdown with purpura and adrenal hemorrhage. It is the purpose of this publication to call attention to the fact that adrenal purpura caused by meningococcus may occur at any age and without an epidemic being present. These cases are emergencies calling for instantaneous diagnosis and treatment.

A patient, either without premonitory symptoms or having had an upper respiratory infection for several days, suddenly falls severely ill. Vomiting and headache is present, or pain all over the body. Spasticity of the neck is absent in most cases. It may be present in the beginning and then vanish due to the general muscle flaccidity as a consequence of the hypoglycemia. After a few hours a purpurish rash appears which spreads very fast. The temperature is high, the blood pressure definitely low. Laboratory findings which confirm the diagnosis are: Intracellular gram negative diplococci found in blood smears taken from a purpuric area; leucocytosis with marked toxic shift to the left; low blood sugar; blood and/or spinal fluid cultures positive for meningococci. But there is no time to wait for the laboratory report. A tentative clinical diagnosis should be made and treatment should be started without the loss of a single hour. Repeated large doses of adrenal cortex preparation intravenously and intramuscularly; injections of adrenalin in frequent doses. This should be followed by antimenigococcus serum intravenously and intraspinally and by sulfonamides as soon as the diagnosis has been completed. From the experience of Kwedar[15] we have learned that some of these patients may be saved. Without instantaneous treatment the prognosis is fatal.

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Amebiasis

If formed stools are examined, what likelihood is there that from a single specimen one will achieve any degree of certainty that *E. histolytica* is present in that particular individual or not? It has been known for about twenty years that not more than 25 per cent of all infections are discovered by a single stool examination, using ordinary direct film technics. The percentage can be practically doubled by also using the zinc sulphate centrifugal flotation technic which separates the cysts from the feces and floats them in the surface film. Even then a single stool examination is not likely to reveal more than 50 per cent of the total number of positive individuals in any particular group. It takes three or four such stool examinations, spaced over a period of nine or ten days, to approximate a 90 per cent diagnostic certainty.—Ernest Carroll Faust, Ph.D., New Orleans, La.; Northwest Med., Vol. 42, No. 12, December, 1943.

Management of Magnetic Foreign Bodies in the Eye

PAUL G. MOORE, M.D.

THE subject is comprehensive and includes the presence of foreign bodies under the lids, in the cul de sacs, within the structures forming the globe, the cornea, sclera and within the globe itself.

It is as important a subject as any in the surgery of the eye. Following the accidental introduction of a foreign body into the eye, there may be:

Loss of time, temporary or total disability, impairment or total loss of sight in one or both eyes, loss of earning power and the loss of a valued and experienced employe for a varying length of time, or permanently. The economic loss is both to the employe and his family, and to the employer.

Considering the importance of this subject, the attention given to it in text-books and literature is very meager.

The disabilities and loss of vision following simple foreign bodies on the cornea are as severe and cause as much loss of time as the intraocular foreign bodies, still their prevention, surgical and after-treatment receive very little attention.

The care of intraocular foreign bodies, their surgical care and after-treatment is intriguing and attracts the attention of anyone taking up the subject of management of foreign bodies in the eye. The treatment and management of foreign bodies on the cornea is just as important as that of intraocular foreign bodies. Foreign bodies on the cornea, if not properly cared for and followed by ulcers of the cornea, can cause as much loss of vision and as much loss of time as an intraocular foreign body. Consequently, the discussion of the management of these minor cases is of first importance.

The first step in the treatment of foreign bodies in the eye is prevention of such accidents. By the wearing of goggles and the use of guards around machines, most accidents from flying foreign bodies can be prevented. The safety men in industry have done a good job in preventing accidents to the eye. Prevention has eliminated large numbers of these cases and saved many eyes and much time. Still some such accidents occur.

The management of foreign bodies in the eye is one of the most important subjects in eye surgery, particularly at the present time when all industry is running in high gear in war production. It is also of importance in the case of war casualties. It is a subject given little attention in textbooks or at the scientific meetings of eye societies until the last few years. Little knowledge of its importance or its technique has been gained in eye courses. It has largely been a matter of individual training and the methods of its technique have been individualistic.

As every individual being is needed in an industrial setup, it is often a catastrophe to have one person disabled in a production line by having a foreign body in the eye, causing loss of production, loss of time, loss of earning power to the individual and possibly the loss of a skilled technician.

The first essential in the proper care of foreign bodies in the eye is good equipment. This does not mean that the equipment must be expensive. Some of the most expensive equipment, such as chairs and lamps may not be the most efficient. If foreign bodies are to be removed in a shop dispensary, this dispensary should have at least a strong chair with a comfortable head-rest in which the patient may be placed before operating. A strong wooden arm chair with a head-rest attached may be used. Some of the specialist chairs which are on the market are efficient. Others have a head-rest which is not strong enough and which cannot be properly adjusted to make the patient comfortable for this operation.

In former days, when the removal of foreign bodies was done by a foreman or a mechanic who was proficient in this operation, the patient was backed up against the wall so that he could not move his head or he was laid out on a bench. These two methods are not advised but are more adequate than some of the chairs sold by instrument houses. The light steel chairs often found in dispensaries are not recommended for this type of work. A strong patient, in trying to

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Note: Because of his wide industrial experience as eye surgeon to Republic Steel Corp., White Motor Co., Cleveland Transit, and Fisher Bomber, and eye consultant, medical staff of Standard Oil Co. of Ohio, DuPont Chemical Co. and Ohio Crankshaft Co., the Editor has asked Dr. Moore to review this important subject.

draw away from the surgeon, can spring the backs of such furniture. If a specialist chair is not available, a patient may be laid upon a flat top table. The disadvantage of using a table is that it is difficult to illuminate the field of operation with the patient lying down.

The next requisite is proper illumination. There are on the market at the present time, lamps for the purpose of illuminating the eye during operations. These lamps are sometimes expensive and are no more efficient than illumination from a 75 watt bulb fitted with a condenser. In most of the lamps sold as specialist lamps, there is a diffusing lens or opalescent screen which prevents all the light rays being concentrated on the field of operation. In this operation in particular, it is necessary to have a sharp, clear light beam playing on the cornea in order to remove a foreign body with the least possible injury to the corneal tissue. A simple method of illumination is illustrated in the following cut.



Operating Chair with Proper Head Rest

The next requisite is a proper magnifying lens. Each operator has his own choice of magnifier. The type used depends on the preference of the individual operator, and his training. Most dispensaries have a binocular loupe, consisting of a metal tube 3" or 4" long with the lenses at the apex, fitted with a metal band which is placed over the top of the head. The objection to this loupe is that the operator cannot approach the field of operation closely enough without striking the patient with the end of the loupe. There is also a binocular loupe with two small magnifiers to be hung in front of one's spectacle lenses. The same objection holds in this case. The operator cannot get close enough to his field of operation. One does not see a watch maker attempt a delicate operation holding his work and instruments at arm's length. He gets as close to his work as possible.

The writer's choice is a simple magnifier, a 10X Coddington loupe. The focal distance of this loupe is ½". With practice, and with proper illumination from the simple lamp described above, foreign bodies can be removed from the cornea by dissection, if necessary, without extensive injury to the corneal tissue. If the workman is to return to work immediately and lose no time, no further injury to cornea must occur by the removal of the foreign body and no corneal tissue must be removed in the operation.

It is also most important that the operator himself have good vision. It is taken for granted that a surgeon would wear proper glasses. Often the physician does not wear his proper eye correction. He does not realize how much visual acuity he has lost due to presbyopia.

A binocular Zeiss loupe is thought to be ideal but is not necessary. If its pupillary distance is not equal to that of the operator, it becomes a monocular magnifier and is clumsy and awkward.

The next essential instrument is the one used for the removal of the foreign body. Foreign bodies which are lying upon the surface of the conjunctiva of the lids or the eyeball may be removed with an applicator wrapped tightly with sterile cotton and moistened with an anesthetic solution. If the foreign body is imbedded in the cornea, this instrument is not efficient and should not be used. As the superficial layer is often wiped off in the effort to remove the foreign body, (some corneas have abnormally soft surfaces and are easily damaged) the use of such an instrument on the cornea is not advised. The most practical instrument for this purpose is a sharp Graefe knife. The old-fashioned eye spud sold by most instrument houses for removing foreign bodies from the eye is about as useful and dangerous as a crowbar would be for picking one's teeth. It has a large dull point which cannot be inserted beneath the foreign body easily and when the foreign body is removed successfully, a portion of the cornea is usually removed with it. It is suggested that this instrument be removed from the instrument cabinet and be put in the kitchen tool chest to be used as a screw driver.

The arrow pointed spud has a thinner blade and, if sharp, makes a useful instrument for removing foreign bodies from the cornea if the foreign bodies are not deeply imbedded. The Graefe knife makes the ideal instrument for the removal of foreign bodies from the cornea but the point soon becomes blunted and must be re-sharpened, for the efficiency of this instrument depends on its sharpness.

The small dental burrs which are recommended for the removal of scale from the cornea may be ideal in some operators' hands but look so

large and clumsy under the magnifying glass that I dread to use them for fear of damaging the cornea. The corneal currette also looks enormous under the magnifier. The chief objection to this instrument is that it is hard to keep it sharp enough to dissect out the charred tissue from the wound.

INSTRUMENTATION AND ANESTHESIA

Before any foreign body is removed from the cornea an anesthetic should be instilled into the eye. Loose foreign bodies may be removed from the lids without an anesthetic but when they lie upon the bulbar conjunctiva or on the cornea, an anesthetic is essential. Previous to the introduction of anesthetics which did not dilate the pupil, a patient would occasionally refuse to have an anesthetic used because he dreaded the blurring vision following dilatation of the pupil. Cocaine formerly was the only anesthetic used in a 4 per cent solution. This drug caused dilatation of the pupil. There are now available several efficient drugs which anesthetize the cornea as efficiently as cocaine did formerly and do not cause dilatation of the pupil. Holocain formerly was used. Its action was too slow and the effect was very slight. Butyn is very popular with some operators. The writer has found metycaine in a 2 to 4 per cent solution as efficient as a 4 per cent cocaine solution. Formerly, when cocaine was used, a patient occasionally slipped out of the chair into the floor. It is hard to believe that the cocaine solution was entirely responsible for this. Pontocain, in a ½ to 1 per cent solution is also an efficient anesthetic.

The instrumentation and the anesthesia having been discussed, the subject of foreign bodies on the cornea will be taken up. Foreign bodies on the cornea consist of bits of carbon or cinders, concrete, sand, fish scales, hulls from seeds, sawdust emery or hot sparks from welding operations.

The greatest number of foreign bodies on the cornea consist of hot sparks or pieces of oxidized metal glowing hot from emery wheels, spot welders, welding operations and cigarette lighters, These sparks or glowing objects, principally red hot particles of metallic oxides, strike the cornea and burn themselves into its surface. The depth of the burn or injury depends on the size and intensity of the heat of the foreign object. At the time of impact, the heat anesthetizes or deadens the nerve endings for some time and the foreign body is not felt in the eye perhaps for several hours. The patient's attention is not called to his injury until he has left the shop and gone home, when, the anesthesia having worn off, he feels something in his eye. Because he cannot sleep, he asks his wife or a neighbor to remove the foreign body.

It is these cases which seek relief at home which suffer the most and have the most damage as a result of trying to remove the foreign body. Crude methods to remove the foreign body are used and risk of infection occurs. Perhaps Crude methods to remove the foreign body are used and risk of infection occurs. Perhaps the corner druggist or the family physician is consulted. He does his best but is often poorly equipped for such an emergency.

The patient presents himself to the eye surgeon, complaining of pain in his eye. Sometimes he gives a history of having been struck in the eye by a foreign body or he may state that during the night the eye became painful and he was unable to sleep, after attempts at removal of a foreign body, the pain in the eye became worse. At the time that the patient is first seen, it is important that a proper record be made, the record giving the name, address and company of the patient and his complaint, also his statement as to what he was doing. The next important thing to be done, even if the patient complains that he is suffering, is to determine the patient's vision in each eye and make a record of the same. The patient will honestly admit his vision at the time of the accident but after talking to his friends and possibly a lawyer, his vision becomes much worse and remains so.

Following the taking of the history, the patient should be seated in a strong chair with a comfortable head-rest, either in front of a good light from a window or a strong electric light as described above. The eye is then examined, the light being focussed upon the cornea and the surface of the latter being thoroughly searched for foreign bodies. With a poor light and with an inefficient magnifier, a great many foreign bodies may be overlooked, particularly in those patients with dark pigmented irides. If the cornea and bulbar conjunctiva are clear of foreign bodies, then the lids should be everted and the upper cul de sac thoroughly examined. It may be necessary to introduce the anesthetic in the eye before a thorough examination can be made. A drop or two of the anesthetic is introduced into the lower cul de sac. The surface of the cornea may then again be examined with a loupe. If the beam of light is not strong enough, it may be concentrated by the use of a condenser in the hand of an assistant.

In a great many cases, it is necessary to use a condenser in order to discover a small foreign body which would otherwise be overlooked. The 10X Coddington loupe is a great deal more efficient in thoroughly searching the surface of the cornea, than the binocular magnifier commonly used. Many operators insist that the cornea should be examined with a slit lamp in order to discover a foreign body. The slit lamp gives a concentrated beam of light and reveals small

foreign bodies and small abrasions on the surface of the cornea but the use of the slit lamp is unnecessary in ordinary industrial work and where industrial cases are taken care of in any number, the use of the slit lamp becomes impossible on account of the time required.

It has been the writer's custom to use a 10X loupe and concentrated beam of light from a clear 75 or 100 watt bulb. The beam of light from a frosted bulb is not sufficient. The frosted bulb causes too great a diffusion of light.

After the surface of the cornea has been studied, the margins of the lids should also be examined to discover any inturned lashes or burns at the margins of the lids or foreign bodies in the lacrymal puncta. A foreign body in the lacrymal puncta which rubs upon the eyeball will cause just as much complaint as a foreign body on the cornea. A badly irritated eye may be searched very diligently and no foreign body found, when, on looking in the puncta, a sliver, a cilia or a bristle from a hairbrush may be found protruding from the same and rubbing on the eyeball. Believe it or not, the writer has drawn three cilia, one after the other, from one puncta in one sitting.

Pieces of emery or of the metallic oxides are the most frequent foreign bodies found on the cornea. These foreign bodies strike the cornea during the operation of an emery wheel or while the person is doing spot welding or from the use of an automatic cigarette lighter. These small particles strike the eye, being heated to a high temperature and burn the tissue, anesthetizing the same at the time of the accident. The foreign bodies which are heated to a low intensity cause very little destruction of corneal tissue and leave no scale on the corneal surface. They can be easily removed with the point of a sharp knife. The particles which are heated to a more intense degree burn themselves into the surface of the cornea and cause a charring of the tissue immediately surrounding them and an anesthesia of the nerve endings.

These foreign bodies are often removed by a fellow workman or by a friend, using a simple applicator. The charred tissue remains in the cornea as a black or brown scale. After a few hours, the tissue immediately beneath the scale begin to swell and push the scale above the surface of the cornea. The pressure of the lid on this foreign body causes intense pain by pressure on the nerves beneath it and the patient is likely to seek immediate relief. This scale can be removed completely with a sharp knife, leaving only a brown staining of the tissues beneath. This gives the patient immediate relief and after the use of an antiseptic solution, he may be sent home or back to work without further treatment if no further injury to the cornea has occurred. If the cornea is denuded during the operation, the patient will have pain and be disabled.

The heat of some foreign bodies is so intense that some corneal tissue is destroyed in addition to the charred area described above. In these cases, there is a white coagulated areola surrounding the charred area. This gives the impression to the inexperienced examiner that he is dealing with an infected ulcer. After the foreign body and the charred scale is removed, there is this white coagulated area left. After experience with this type of case has been acquired, no further effort is made to remove this white area, as it is merely sterile tissue coagulated and turned white by the heat from the foreign body. The eye is treated with a mild antiseptic and the white area left untouched removal. At the end of four days, the whole for several days, no attempt being made at its white area, perhaps 2-3 mm. in diameter, may be lifted out of the cornea, leaving a clean, sharply limited crater which gradually heals over by proliferation of the epithelial layer. This latter type of injury may be mistaken for an infected ulcer and may be treated with strong antiseptics with extensive destruction of the corneal tissue and delay in healing. Good judgment must be exercised in deciding whether the white area is due to destruction of tissue by heat or sloughing caused by an infection. When caused by heat, the tissue is of an intense white color while sloughing caused by an infection has a yellowish tinge and shows a tendency to increase in size day by day.

OBSERVATION OF CASES

These cases should be kept under observation and should be examined every day. The operator should not be too eager to treat vigorously this type of case when first seen. He will save himself a long period of treatment and the patient a tiresome period of disability by waiting 24 hours to discover whether there is an increase in the injured tissue. In removing the foreign body, the operator should carefully dissect out all the charred tissue beneath the same, for if portions of the charred tissue are left, the patient complains as bitterly of them as he did of the original foreign body. This type of foreign body is sterile when it strikes the eye and, if the wound has not been tampered with, there should be no ulceration following the removal of the foreign body. If the corneal tissue surrounding the foreign body is damaged in the removal of the former or if the surface is denuded by the use of improper instruments and poor illumination, the patient will complain bitterly of pain and will seek further assistance and the length of his disability will be increased.

Following the proper removal of the foreign

body, if there has been no injury to the surrounding corneal tissue, a mild antiseptic is introduced into the eye. The writer has used, over the last 25 years, a zinc sulphate solution 1/5 per cent and has had no ulcers develop in any foreign body case except those treated before coming to him for assistance. It is immaterial what antiseptic solution is used. Each operator has his own preference. Zinc sulphate 1/5 per cent, metaphen, merthyolate, mercurochrome and others all have their champions. Perhaps the wound would heal as readily and with no ulceration if no antiseptic whatever were used. The use of iodine or phenol or trichlor acetic acid is unnecessary in these uninfected cases.

DISADVANTAGE OF BANDAGING

Following the removal of this type of foreign body, the eye should not be bandaged. This is contrary to all the textbooks and the teaching of a great many professors. The proof of this treatment is in the results obtained. This has been shown by the results obtained over a period of 25 years, in the care of several of the largest industrial concerns in Cleveland, in the cutting down of lost time and the non-occurrence of ulcers. Where the system of bandaging eyes is used, in some shops, large numbers of employes may be seen working at machines with one eye bandaged over a longer period of time than would be necessary if treatment without bandage were used. The reasons for not bandaging this type of case are, first, the wound in the first place is not infected, second, if the foreign body is properly removed without injury to the corneal tissue, the patient is not going to suffer pain and covering the eye is not necessary, as the corneal surface is not denuded.

The disadvantages of bandaging the eye in this type of case are that closing of the eye permits the development of ulcers. There may be pyogenic organisms present on the conjunctiva which will multiply under a bandage, due to the presence of a traumatized tissue and moisture and heat. The wound, if exposed to the air, will heal more rapidly and the patient will suffer less loss of time. If, in the removal of a foreign body, the surface of the cornea is removed, due to poor technique, the patient will suffer increased pain and bandaging the eye may become necessary. The use of ointments in this type of case is not advised. It is the opinion of the writer that ointments tend to seal in whatever infected organisms are present. In their application, the patient is apt to introduce an infection and if the base of the ointment is not a semi-fluid, the introduction of the ointment into the cul de sac acts as a foreign body and causes discomfort. The above statements are directly contrary to what is generally taught but again, the proof of the matter is in the results obtained. Hot compresses to relieve the congestion and soreness are just as efficient.

AFTER-TREATMENT

The after-treatment of these cases is important. If the accident is treated in the shop dispensary, and a competent nurse is in charge, the patient should return to the shop dispensary before going off duty and hot compresses should be applied to the eye. He should be given instructions as to how to apply hot compresses to the eye at home. He should be seen every 24 hours by the surgeon or his assistant until evidence that the wound is covered with epithelium is definite. Some operators consider that flourescin should be dropped in the eye to discover if there is any possible break in the corneal surface. The use of flourescin is unnecessary in this type of case and the dropping of flourescin in the eye may lead to an infection of the wound, for it has been demonstrated that pyocyanus bacilli will live in a solution of flourescin.

The operator must be a judge of human nature and if, in his wisdom, he decides that the patient cannot be trusted to keep his fingers out of his eye or if his sanitary condition is such as to lead the operator to believe he is unable to give proper treatment to the eye, then and then only should a dressing be placed over the eye. If, due to meddling or to some outsider's faulty technique, an ulcer develops, then more rigorous treatment must be followed. If a small gray margin is seen to develop around the wound on the second day, which was not present on the first day as a result of heat, then the wound must be wiped out with a stronger antiseptic solution. Some operators prefer iodine which may be used in 3½ or 7 per cent solution. Iodine is a member of the halogen group and one expects to find, on the second day of its use, some gray tissue. This is due to the use of the antiseptic and not due to infection. Phenol and alcohol can be used or trichlo-acetic acid. It is the writer's opinion that the penetration of the antiseptic is not so deep or extensive in the use of these latter as in the use of the iodine. Following the use of the stronger antiseptic, if there is any circum-corneal irritation at all, the patient will be more comfortable during the next 24 hours if a 1 per cent solution of atropin sulphate is instilled in the eye at the office. The use of zinc sulphate ⅕ per cent solution and hot compresses is advised as home treatment. The treatment of extensive ulceration which may follow such an injury, will be taken up below under eye ulcers. A certain number of eyes show intense circum-corneal irritation after being struck by a foreign body especially if it has remained in over night. A drop of 1 per cent solution of atropin should be instilled in these eyes when first treated. One application is generally

sufficient. The patient is more comfortable and the cycloplegia or blurring does not last long.

REMOVAL OF FOREIGN BODIES FROM THE SUBSTANCE OF THE CORNEA

These foreign bodies consist of sharp pieces of metal, generally steel, which penetrated deeply into the cornea. They frequently penetrate at an angle and lie between the layers of the cornea. They may penetrate as far as Descements membrane or may penetrate the same, extending into the anterior chamber. These foreign bodies, if they come from a machine tool, as a general rule, are not infected and a great many times strike hot. In the treatment of such accidents, the patient is seated as before and a careful examination is made of the cornea to discover the wound of entrance. If the foreign body lies in the corneal tissue, it may be difficult to remove the same unless the wound of entrance is accurately located in reference to the position of the foreign body. The foreign body is removed, if possible, through the wound of entrance as this prevents extensive injury to the cornea. After using an anesthetic, one edge of the foreign body is located with a sharp knife and an effort is made to tip the foreign body out of the wound. In order to do this, it may be necessary to lengthen the wound.

Extensive dissection of the cornea should be avoided except to lengthen the original incision. The knife may have to be introduced as far as Descements membrane in order to get under one end of the foreign body. During tre removal, aqueous may leak out around the foreign body. If the operator is careful, he may be still able to lift the foreign body out of the wound and not lose the contents of the anterior chamber. Following the removal of such a foreign body, it has been customary to use a 3½ per cent iodine painted on the wound as the deeper tissues of the cornea have been exposed. If the injury has been extensive, a drop of 1 per cent atropin solution will make the patient more comfortable during the first 24 hours. This type of case, particularly if the anterior chamber has been opened, should be dressed. The only antiseptic solution used in addition to the iodine, is 1/5 per cent solution of zinc sluphate. No ointments are advised. There should be no more pain from this type of accident than from the removal of a simple foreign body. This type of case should be examined every 24 hours and the period of disability will extend, undoubtedly, over from 10 days to two weeks.

On account of the wound extending deep into the corneal tissue, the wound does not heal as rapidly and the patient should not work during this period of time.

It is remarked here that foreign bodies on the cornea which occur in the neighborhood of the limbus cause more pain and discomfort than those occurring in the central area of the cornea. The disabilities resulting from such types of accidents is of interest to the patient as an employe and to the employer. The length of time lost following the removal of a piece of emery from the eye need not be more than 30 minutes or the time necessary for the patient to go to the eye dispensary and for the foreign body to be removed. It may become a matter of days if the foreign body is improperly removed or if an infection develops. Hot foreign bodies which leave uninfected wounds and are removed from the cornea without further damaging the corneal tissue, leave only thin nebular scars which cause no impairment of vision unless directly over the center of the cornea.

There need be no impairment of vision in the cases where the foreign body is in the center of the cornea if we have the honest cooperation of the patient later in the estimation of his vision.

If the foreign body causes destruction of tissue, if the burn is deep in the tissue following the accident, a denser scar results and possibly a faceting of the corneal surface. The presence of these dense scars or facets in the central area of the cornea may cause impairment of vision. The nebular scars 1-2 mm. in diameter following emery burns, a great many times disappear after several weeks. Where the foreign body penetrates into the deeper layers of the cornea, a permanent scar is likely to result. If the scar occurs in the periphery and is less than 5 mm. in length, there should be no warping of the corneal surface or impairment of vision unless the scar lies in the central area. If one of these wounds becomes infected and an ulcer develops, the disability may run into weeks and months. The entire cornea may be scarred, causing loss of all useful vision and, if the infection is virulent and the anterior chamber becomes infected along with the deeper tissues of the eye, loss of the eyeball may result.

INTRAOCULAR FOREIGN BODIES

Intraocular foreign bodies are the result of striking on hard pieces of steel with another hard piece of steel. A blow on a hard tool in a lathe will invariably cause a chip to fly from the tool. This chip travels at a high velocity and may penetrate the anterior and posterior walls of the eyeball. In the majority of cases, the chip loses its velocity and becomes imbedded in the retina. Chips from a die will also penetrate the eye. When a poorly fitting punch strikes the die, a chip may fly from the margin of the die. Intraocular foreign bodies also result from striking on a cold chisel with a mushroomed head. A blow from a steel hammer on any hard piece of steel may result in a chip flying off and penetrating the eye.

In most of these foreign bodies from dies or tools, there is a certain amount of heat and they

are sterile when they strike the eyeball, causing no infection of the same. Foreign bodies from tools used in a garage or from hard steel portions of a car are generally infected and these cases, as a rule, result in loss of the eye due to infection. When an accident case presents himself to the surgeon, it is important to secure a history of what the man was doing and the character of the work, the tools he was using and what he did at the time of the accident. In this way an idea can be gotten as to whether to look for an intraocular foreign body.

A great many times the patient complains merely of having felt a stinging pain in the eye following which he has no complaint. That anything serious has happened is called to his attention by his vision being blurred. If the foreign body has passed through the lens, a cataract will form and his vision will become blurred. In a great many cases, months or years may elapse before the foreign body is discovered. Then, on examination, a siderosis or discoloring of the iris and lens is discovered, indicating that there is a piece of iron within the eye. Often discoloration is the first indication that an intraocular foreign body is present.

THE MANAGEMENT OF SUCH CASES

The history having been taken and examination made of the outer tissues of the eye, the wound of entrance may be discovered. Sometimes, if 24 or 48 hours have elapsed, the wound closes and a very careful examination must be made in order to discover the scar. Wounds through the cornea may be seen with the use of a strong light and a 10X loupe. If the foreign body has passed through the iris, a hole in the iris will be discovered. A wound in the cornea with a history of having struck a hard piece of metal, is a positive indication for an X-ray examination.

By examining the eye with an ophthalmoscope, a great many times, if the lens is clear, a foreign body can be seen in the vitreous or lying on the retina. If the foreign body has passed through the lens, there is the trace through the lens tissue, also a wound in the anterior and posterior capsules of the lens. This can also be discovered with a 10X loupe. If the wound in the capsule of the lens is small, the wound may close, preventing any large amount of fluid entering the lens and the major portion of the lens remains clear, permitting an examination of the interior. If the wound in the anterior capsule is large, more than 1 mm. in length, fluid is admitted to the lens tissue and a cataract begins to form in two or three hours. If the wound is 3 mm. or 4 mm. in extent, there may be a complete opacity of the lens in 24 hours.

An X-ray examination is the next important step to take. An elaborate or complicated system of localization is not required. The writer believes that the old method, using Sweet's apparatus, gives the best results. The position of the foreign body can be localized within less than 1 mm. of error if the patient is cooperative. Various methods have been devised for the localization of the foreign body.

Intraocular foreign bodies should be removed, if possible, in the first 24 hours. First, to remove an infected body; second, to prevent the organization of fibrin around the foreign body, causing it to be fixed in place and rendering its removal difficult.

REASONS FOR HOSPITALIZATION

Intraocular foreign bodies can be removed in the office but, if hospitalization is at all possible, it is advised. In this state, where the Industrial Commission takes care of the hospital expense, there is no excuse for these cases not being hospitalized, if a bed is available.

The conditions under which one operates in the hospital are more ideal than in the office. In case of emergency, proper facilities for treatment are present, and the patient can be kept under control. If he is sent home, we have no guarantee that he will follow our treatment or that he will remain at rest as ordered.

TECHNIQUE OF OPERATION

At the time of examination, the point of entrance is definitely determined. The path of the foreign body through the iris and lens is mapped out and if possible, its location in the retina or vitreous is discovered by the ophthalmoscope. Also, its location is definitely determined by use of the X-ray.

The question of whether it is to be removed by the anterior or posterior route must now be decided. Formerly, the writer was accustomed to remove all foreign bodies by the anterior route. The use of the posterior route is often debated. In certain cases, the posterior route is the one of choice.

INDICATION FOR THE USE OF THE ANTERIOR ROUTE

If the foreign body is small, less than 1.5 mm. in length, and has passed through the cornea with or without injury to the lens, it may be possible to remove this foreign body by the anterior route. If the foreign body is not imbedded in the retina or has not been within the eye for over 24 hours, it can be drawn forward and brought through the zonule without damage to the lens, into the posterior chamber. From the posterior chamber it may be hopped through the pupil into the anterior chamber and removed through the original opening or through an incision at the limbus made with a keratome.

If the foreign body is larger than 1.5 mm. it, undoubtedly, has caused severe injury to the lens and there is no objection to withdrawing by the

anterior route, as further injury to the lens is not important.

If the lens has been uninjured, removal of a large foreign body by the anterior route is almost certain to cause injury to the lens. It is preferable to make an opening over the position of this foreign body in the sclera and remove the same by the posterior route.

INDICATIONS FOR REMOVAL BY THE POSTERIOR ROUTE

If the foreign body is small, 1.5x1 mm., and has passed through without injuring the lens and has become imbedded in the retina, and attempts with a giant magnet have resulted in no movement of the foreign body, it is advisable to make an incision in the sclera and remove the foreign body by the posterior route.

POINT OF ENTRANCE FOR REMOVAL BY POSTERIOR ROUTE

The position of the foreign body having been determined, it is advisable to make an opening in the sclera over the location of the ora serrata. At this point, the retina is most firmly attached to the underlying sclera. At this point, the tip of the magnet can be inserted in the wound and in a great many cases, the foreign body presents itself at the point of incision. If the foreign body is small and one is certain of the position, the introduction of the tip of the magnet may become necessary. A great many operators object to introducing the tip of the magnet within the eye. If one is careful about his technique and is sure of his localization, the tip can be introduced without great damage to the vitreous and the foreign body removed.

It has been advised, following the removal of a foreign body by the posterior route, to tack the retina back in place by the use of diathermy. If the incision has been made as described above in the region of the ora serrata, the detachment is not likely to occur. If the vitreous has been badly damaged by the entrance of the foreign body and if hemorrhage has occurred from the choroid or retina into the vitreous, there will be the formation of fibrous bands which will draw the retina off its base no matter how much attachment results from the use of diathermy needles.

There are several methods of incising the sclera. It is the author's choice to use a Graefe knife and make a stab incision over the margin of the ora serrata, then turn the knife, forming a V-shaped incision whose limbs are 2 mm. long or the width of the knife. This has been a large enough incision to remove any foreign body encountered.

A V-shaped incision is made in the conjunctiva previous to incising the sclera between the insertions of the external and inferior rectus muscles. The sclera being exposed, an incision is made as described above about 10 mm. from the margin of the limbus. After the withdrawal of the foreign body, the tongue of the sclera drops back into place and requires no suturing. The conjunctival flap is drawn over the scleral wound and closed with a running suture. I am not in favor of using the trephine for making the incision in the sclera. If the flap is not hinged at one edge, there is no way of closing the opening. If the foreign body is a little larger than the opening, difficulty will be experienced in removing it through the small round hole and an incision must be made to enlarge it.

After closure of the wound, atrophin 1 per cent should be instilled, the eye should be dressed and the patient kept in bed under the same conditions used for a cataract case.

The operator's judgment must be used in the after-treatment as to length of time to keep the patient on his back, as to the length of time he is to be kept in bed and when he can be discharged from hospital care. The majority of these cases will be incapacitated for at least two weeks and the severe cases may be incapacitated for as long as eight weeks. The mistake that is made in the treatment of intraocular cases is that they are returned to work before the eye becomes absolutely quiet and has recovered from the use of atropin.

Some operators are in the habit of giving foreign proteid immediately after the operation. I do not believe this is necessary unless I am suspicious that the foreign body is infected and only in case the eye become irritable within 24 or 48 hours.

I believe if there is any possibility of the foreign body being infected, it is far more feasible or profitable to give the patient one of the sulfa drugs, whichever the operator is accustomed to use or has found best. The eye should be kept under the effect of atropin as long as there is any pink reaction around the cornea and for a week or ten days following the subsidence of all congestion.

It is a fairly safe rule, following injuries to the eye or the occurrence of intraocular foreign bodies that an infection, if present, will develop at the end of the fourth day. If no inflammatory action occurs by that time, it is safe to conclude that the eye is not infected. This does not mean that a severe inflammatory action may not occur due to the trauma and insult to the ocular tissues. A severe injury to the eye may be followed by a severe reaction in the iris, in the ciliary body or in the retina and choroid. This is evidenced by congestion of the circumcorneal vessels, exudate on the surface of the iris with a small pupil and congested vessels showing in the iris tissue itself. To prevent the development of such a condition and the severe after-results of an iritis, it is good therapeutics and

is the rule of the operator to instil atropin 1 per cent solution in all these cases at the time of first aid and to continue this treatment three times a day. All fresh surgical or incised wounds made by a penetrating foreign body should be touched or wiped off with tincture of iodine, official 7 per cent or milder 3½ per cent.

It is the writer's opinion that all intraocular foreign body cases should be put to bed. Most strong, healthy individuals who suffer a minor eye injury, are opposed to such treatment but it has been our experience that rest in bed is one of the best factors in securing good results. This does not mean sleeping in bed during the night and walking around the ward during the day. Some small hospitals, short of help, may be tempted to allow these cases to wait on themselves. Where the eyeball has been opened in the removal of a foreign body, it is wise to treat this case the same as where a cataract has been removed.

Formerly it was considered wise to introduce, every three or four hours, some antiseptic solution such as mercurochrome 1 per cent, argyrol 10 per cent, merthyolate 1-5M, yellow oxide ointment or various other antiseptic solutions. I do not believe that such routine treatment is necessary unless the conjunctival surfaces are infected or the margins of the lids are unhealthy. The above described treatment with iodine at the time of first aid, is sufficient for the first 24 hours. In these cases, it is the author's idea that a dressing should be used to prevent movement of the lids and eyeball, to prevent touching the lids with the fingers, to relieve irritation from light and keep the eye at rest. This is an entirely different situation than that described under foreign bodies on the cornea.

If any medication is to be used, atropin 1 per cent solution should be ordered instilled three times a day. This is not necessary during the first 24 hours if atropin has been used at the first dressing. Sufficient narcotics should be ordered to make the patient comfortable. As a general rule, there is very little pain following the removal of a foreign body from the interior of the eye unless the iris has been severely damaged or a portion of it has been caught in the corneal wound. Under these circumstances, codein may be necessary. The writer avoids morphine on account of its liability to cause vomiting. If the patient is restless, some form of the barbitals may be ordered.

It is the writer's opinion that a good cathartic in these cases is required and I have not hesitated to give calomel, Gr. 2 and magnesium sulphate. The disability and length of time in bed and in the hospital depend on the reaction following the injury and the severity and number of tissues involved.

A foreign body in the anterior chamber which has penetrated the cornea only may not cause a disability longer than four days, including length of time sufficient to close the wound in the cornea. Where the iris has been injured, the disability may run as long as six to eight weeks due to a traumatic iritis developing after the injury; a cyclitis may also develop.

Where the lens has been injured, if the wound in the anterior capsule is small, this may close in 24 to 48 hours and very little damage to the lens occur. If the wound is large and the aqueous enters the lens, swelling of the lens follows with possibly a temporary increase in tension. If this increase is gradual, with very little pain, no surgical treatment may be required. If the tension goes up rapidly with the pain accompanying acute glaucoma, it may be necessary to make a linear incision and wash out the lens tissue. In the majority of these cases, in young adults up to 30 years old, the lens may absorb gradually, with no unfavorable results. Later a needling of the capsule of the lens may be necessary.

These cases must be examined carefully every day and watched for evidences of irritation. If the circumcorneal congestion increases, if the color of the circumcorneal congestion changes, becomes a dusky red and the patient complains of pain through the night, particularly if deposits occur on the posterior layer of the cornea, one becomes suspicious of a deep inflammatory reaction in the iris, the ciliary body and possibly the choroid. The fellow eye must be carefully watched for sensitiveness to light, congestion of the small vessels around the cornea and congestion of the iris vessels themselves. These signs make one suspicious of a sympathizing iridocyclitis and the removal of the irritating eye must be considered.

At this point, it may be apropos to consider the subject of enucleation of the eyeball. When should it be done? There are certain types of injury in which it can be definitely stated at the time of examination that removal of the eyeball is imperative. A lacerated wound across the cornea extending into the ciliary body with hemorrhage into the anterior chamber invariably is accompanied by the loss of the lens and a deep injury to the ciliary body. It is safe to say that such an eyeball should be enucleated immediately. The eyeball invariably is soft, the lens has been expressed and extensive injury to the ciliary body has resulted. There is blood in the anterior chamber and possibly in the vitreous.

There is always the possibility of infection and the patient can be told that he will recover with no vision or what little light perception he has will disappear in six to eight weeks; that due to the hemorrhage into the vitreous, extensive scar formation will form within the eye, causing a detachment of the retina and shrink-

ing of the eyeball. He can be told that following an enucleation, his disability will last ten days, after which he can return to work and if he elects to keep the eye, he will be disabled from two to four months with a chance of having a painful eyeball which will become irritable whenever the weather changes or if he catches cold or overexerts himself. He will also be running a certain amount of risk to his fellow eye. The surgeon can definitely state that he will have a poor looking eyeball which will gradually shrink in six to eight months, leaving a small shrunken stump with no vision and that he will make a much better appearance with a good fitting prothesis.

A second indication for enucleation is the appearance of an irritation of the fellow eye indicated by sensitiveness to light, a congestion of the vessels around the cornea and a congestion of the iris vessels themselves. Much importance has also been laid to the presence of white cells in the aqueous, seen by the aid of the slit lamp.

A third indication for removal is the development of a painful eye following removal of an intraocular foreign body. If there are adhesions of the iris to the lens, if the lens has been injured and perhaps a portion has been removed, if there is an anterior synechiae between the iris and the cornea and the eyeball remains painful and irritable, enucleation of this type of eye is indicated. The operator is justified in telling the patient that this eye will never be of any use to him, all useful vision has now been lost, the lens has been destroyed, the iris will remain irritable or, if it does quiet down, several weeks of time will be required; there is always the possibility of the eye becoming irritable at a later date, causing extreme pain and disability and inability to work.

As a general rule, the vision in these eyes is limited to light perception and, after the lapse of several months time, light perception may be lost.

Another indication for the removal of an injured eye is the fact that it remains painful and prevents the patient from securing proper rest. It is interesting to see how long a patient will continue to keep an eye which has recovered from the inflammatory reaction, which shows no more congestion but still remains painful. He will not admit that he has any pain and still will show evidence of same on his face. Following the removal of the injured eyeball, his expression changes and he is free to admit then that he did have pain previous to the enucleation.

The writer probably has erred in being conservative and has not ordered the immediate enucleation of eyes which he knew would have to be enucleated later. Rather he has considered it good psychology to consider the feelings of the patient and his friends and allowed him to keep his injured eye four or five days until the patient realized that the eye was a total loss. This theory may be criticized and it may be said that immediate removal should be insisted on. The writer has never lost a fellow eye due to irritation from this conservative treatment.

The disability following foreign bodies in the vitreous or in the retina will be discussed. A foreign body which has passed through into the vitreous body may be removed and if the foreign body or the tissues were not infected, a complete recovery of the eye may occur with no loss of vision. Hemorrhage into the vitreous need not necessarily follow an intraocular foreign body even if the sclera must be opened and the tip of the magnet introduced. The tip of the magnet may have to be introduced far enough to pick up a foreign body from the retina or the posterior portion of the eye and recovery may occur without any serious loss of function. The writer has introduced forceps through a scleral opening, passed the same into the vitreous, picked up a copper fragment with complete recovery and no loss of vision. The criticism has been made that the use of the posterior route leads to detachment of the retina. This has not been the experience of the writer. Foreign bodies have been removed from the interior of the eye which were imbedded in the retina and were covered with fibrin with recovery of useful vision. In one case particularly, the foreign body had been present one year.

Foreign bodies from automobile parts such as axles, cotter pins and tools used around automobiles invariably result in infected wounds and infections of the entire eyeball. These particles carry the infection into the eye at the time of the accident. If the foreign body is in the deeper layers of the eye, four or five days later, a mass of organized exudate can be seen covering the fundus. No view of the fundus details can be seen. The anterior structures of the eye may be normal and uninjured. When such an eye is removed and opened, the infected vitreous is found in the posterior portion of the fundus and pus is seen developing throughout the vitreous body. Such an infection is seen, as a general rule, within four or five days after the accident. Sulfa drugs may be given and the infection held under control but nothing is to be gained by keeping such an eyeball. Even if the infection is under control, the eyeball heals with a mass of exudate in the vitreous which finally pulls the retina from its attachments and the end result is a shrunken sightless stump. Enucleation should be done as soon as the abscess is discovered.

Following enucleation, it has been the writer's custom to introduce no foreign substance to give greater mobility to the prothesis. I believe that as good a cosmetic result can be obtained without the use of glass or gold balls as with.

Irritation of the Nasal Mucosa in Industry

FRED W. DIXON, M.D.

THE nasal mucosa of the individual varies in its reaction to irritants. The prevalence of these irritations of the upper respiratory passages of industrial workers has greatly increased in the past year. This condition, while not usually fatal, can cause much discomfort and be the direct cause of absenteeism. It can be remedied only by eliminating as far as possible the causes and by different type of work.

That there has been an awakening of public opinion to these facts is shown by the recent action of the Industrial Commission in the various States to include these irritations of the nasal mucosa in their list of compensable claims. In a survey made last month, eighteen States have already done this in whole or in part. The Industrial Commission in the remaining States do not include inhalants affecting the upper respiratory passages. Some strangely enough do include inhalants affecting the lower respiratory tract. Some States do not recognize occupational diseases; others are not industrially located. The Industrial Commission in many States are keenly alive to their responsibility—California and Ohio being noteworthy.

In three of the eighteen States recognition of this occupational disease has been in force for such a short time that no estimation of its prevalence could be given. In the first six months of 1943 there were in Ohio 91 claims for compensation resulting from chemical irritation of the nasal mucous membrane, with 389 days lost. There were, however, many times this number which, while uncomfortable, continued to work.

The increase in the number of persons so affected is due to several factors: Employment of all available man power regardless of their fitness; utilization of all machines creating more irritants; the use of make-shift plants without regard for proper ventilation; longer working hours allowing less time for the mucosa to recover.

The irritants generally fall into two classes: (1) Dusts including mineral, plant, and animal. (2) Vapors. Of the mineral dusts, the main offenders are carborundum, iron, aluminum, and bronze. The plant irritants most frequently encountered are cotton, wheat flour, and wood dust. The animal eminations are mainly from wool and furs. Under a mixed group would be the atmospheric dust of that particular industry.

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Concerning dust, it is interesting to note that the particles which do damage to the respiratory system are invisible to the naked eye, that is under 10 microns in size (a micron is 1/25000 of an inch). Under vapors, the most frequently encountered are the oils and the alkaline watery solutions, used in grinding. Likewise could be added, the sprays from paints and varnishes, and the fumes from acids of which chromic acid is the greatest offender.

Grinding in industry may be either wet or dry. When wet grinding is employed either an oily or an alkaline solution is employed. The cutting oil is lemon yellow in color and has as a base mineral petrolatum and retains its oily characteristics. In this oil accumulates small sharp metal particles in the process of grinding. This oil plus these particles, when coming into contact with the nasal mucosa, causes irritation. Most machine tool plants reclaim their oil. This may be done by filtration or centrifugal force. The frequency which the oil is changed may depend upon the amount of grinding or upon the judgment of the operator. Soluble alkaline emulsions may be used, these are purchased in compounds and diluted three to one hundred times. These solutions may be discarded when dirty or only the sludge discarded and more dilute solution added. These solutions are not sterile and may be loaded with bacteria which, when implanted upon an already irritated mucous membrane, cause further involvement.

In the dust-producing industries the dust itself may not be irritating but the particles may contain oils, resins, glucocides, and alkaloids

which may be irritating or cause allergic reactions. Wood dust in wood working plants or in the manufacture of paper has been known for some time to be irritating to the nasal mucosa. The amount of irritation is in proportion to the type of wood used—the hard wood dust is finer, harder, more penetrating, and hence more irritating.

Repeated air analysis would show concentrations of dust. This concentration varies in the distance away from the grinding or polishing machine. Probably the head band sampling apparatus which samples near the nose of the operator is best. Only a few States have prescribed the maximum permissible concentration dust fumes, vapors and gases in their relation to toxic thresholds. The use of masks as a preventive even when supplied to the precision grinder is generally not used. His reason being that it is unbearable for prolonged use and in very accurate work a mask interferes with his vision.

The nasal mucosa on inspection, at first, is red and irritated. Later, dryness of the mucosa is seen with subsequent crusting and bleeding. Many of the workers on reaching this stage will suffer from repeated colds. The congestion of the nasal mucosa will produce, in some individuals, headaches of varying intensity. Where there is an atrophy of the turbinates or a septal deflection, the mucosa of the pharynx in turn becomes dry and irritated. Most of the persons so affected soon recover when withdrawn from exposure.

In the enormous production effort made by industry, scant time is given the questioning of employable persons as to their allergic histories. Yet, to do so would often disclose his unfitness for this job. When irritation of the nose and throat do develop, it is often difficult for that individual to secure release and transfer to another industry.

It is possible in the construction of a plant to remove by suction much of the dust encountered. Many of the newer type of machines have this attachment. Many of the plants have a ventilating system. These may be inadequate or fail in their purpose. Some years ago, 20 perforations of the nasal septum in chromium workers were observed by the author, due to a blocked suction pipe. Many of these perforations occurred after one or two weeks' exposure. There was usually loss of the cartilaginous septum for which nothing could be done. Yet, this injury is at present a cause of rejection with the armed forces.

CONCLUSION

The nasal mucosa of certain individuals vary in their susceptibility to irritation. This should be recognized by industry.

Careful questioning before employing such persons should be of value in those industries where dust, sprays and irritant fumes are encountered.

Where sufficient irritation of the nasal mucosa is encountered, these persons should be transferred to a different type of employment. Adequate ventilation, properly controlled, will relieve most of this hazard.

Shock

In the diagnosis of impending hematogenic shock, the severity of the trauma, its duration, evidence of dehydration, history of exposure to cold and an estimation of the amount of blood or plasma loss are all important factors in deciding whether or not the injured is likely to develop shock. Determination of the hematocrit and serum protein content is helpful in watching the course of the syndrome but because of its progressive nature frequent blood examinations are necessary for adequate observation. This procedure is, of course, too time-consuming to be practical if a large number of injured people are to be cared for. It is important to correct a common impression that low arterial pressure is the first sign of hematogenic shock, for a blood pressure within normal limits may be maintained to within a few minutes before death. Weakness, dizziness, decreased acuteness of sensation, cloudy sensorium, subjective coldness, decreased body-temperature, cold moist ashen skin, low arterial pressure, sighing respiration, rapid pulse, and "tic tac" heart sounds are important clinical findings. Observation of the mental state, the appearance of the skin and estimation of the adequacy of the peripheral blood flow are the best clinical guides to the severity of the condition. A moist ashen skin accompanied by low arterial pressure and cold extremities means arteriolar and venular constriction secondary to a significant reduction in blood volume. In this stage, treatment is very necessary and unless the response is rapid, the prognosis is grave. On the other hand, the presence of low arterial pressure and a pale, warm or only slightly cool skin in a patient with no decrease in blood volume does not indicate a grave prognosis for the condition is due to vasodilatation and tends to recover spontaneously or responds favorably to vasoconstrictor drugs. Hematogenic shock must be differentiated from congestive cardiac failure, ectopic tachycardia, cardiac tamponade and sudden myocardial infarction.—M. S. Chambers, M.D., Flint, Mich.; Jour. Mich. M.S., Vol. 42, No. 11, November, 1943.

Maxillo-Facial Injuries

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BECAUSE of the anatomical contiguity of the eye, nose, sinuses and related tissues, severe injury to the region of the face often involves combined damage to these structures. Unless properly evaluated and repaired, healing may take place with permanent disability which could have been avoided. Not only must the immediate trauma be diagnosed but the probable end-result after repair must be visualized. The rhinologist may be fully able to repair the damaged structure, but the possibility of early and late eye complications incident to facial injuries should warn him that a consultation by an ophthalmologist is desirable.

The complicated articulations of the bones of the face make injuries to this part of the anatomy of varying degrees of seriousness, depending upon the type and location of the injury. That injuries of this nature are on the increase is understandable when we realize the progress of modern science. For instance, all automobiles are now equipped with shatterproof glass with the result that in an accident, the windows offer the resistance of a solid instead of a breakable object. The airplane is becoming more and more a part of our mode of travel and accidents occurring here, if not fatal, will in part almost always include facial structures. In industry the possibility of severe injury by carelessness or breakage of machinery is always present. A new factor responsible for maxillo-facial injuries is the present war. Never before in any war has there been the amount of wildly flying shrapnel from bomb and gunfire that is facing our soldiers of today. The care of the men wounded in battle will probably unfold great refinements in surgical technique. However, the fundamental relationship of structures of the head and face must be thoroughly understood in the repair of these wounds.

SOFT TISSUE INJURIES

In discussing these complex injuries one can naturally begin with the care of the wounds of the soft tissues. In this regard it is important to remove all foreign particles from wounds, otherwise, unsightly tattoo marks are apt to remain. Brisk scrubbing with soap and where necessary, ether should be used. One should not overlook this simple procedure. It is important to spend an ample amount of time to remove all foreign particles, because their subsequent removal is difficult and not always satisfactory.

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Many cuts and lacerations have shelving borders, that is, edges which are not at right angles to the skin surfaces. With these one can profitably, with a sharp and pointed knife, reduce the cut edges to a 90 degree angle to the surface so that there is no bevelled effect. This avoids wide and depressed scars. In the case of irregularly lacerated skin edges, or those with frayed margins it is best to retrim the margins so that they are straight. One should use the knife rather than the scissors, so as to avoid the crushing effects of the latter. It is important to secure good apposition of the skin without tension on the flaps. Over the cheeks and the dorsum of the nose this is possible by simple undermining of the skin with the scissors. However, over the nasal tip because of the anatomical peculiarities of the skin, satisfactory relaxation and mobilization is generally impossible. Therefore, in this area it may be necessary to use skin flaps from adjacent areas.

In handling skin margins the use of crushing and bruising thumb forceps should be avoided. To satisfactorily manipulate skin one may use fine skin traction hooks, which are just as secure as the above mentioned forceps, or, use fine mouse-teeth forceps with the teeth in the longitudinal plane rather than in the lateral plane. Traction sutures of silk may also be used for tension. Where there is laceration of the lip one should be sure that the vermillion portions are carefully aligned. Where the cartilages of the nose are cut through, one should reappose them and splint them with the surrounding tissues as well as with mechanical aids. It is difficult to rely on cartilage suturing alone.

Debridement of wounds is, of course, important. However, it seems more important for us to

caution against excessive debridement. Small pieces of bone in the anterior wall of the maxmillary sinus unless they are absolutely free and unattached, should be carefully replaced into position and left alone. Flaps of soft tissue should be sutured into place and given a chance to survive. Isolated pieces of cartilage should not be discarded, as sometimes in clean wounds, they can be replaced and become anatomical supports and bridges, thus saving the patient the discomfort of subsequent plastic operations. Never discard that which nature may save for the patient.

SUTURING WOUNDS

In suturing wounds one may use wire, horsehair, nylon, silk, or cotton. It is important to have the coapting edges without tension and at right angles to the skin surfaces. Have epithelium to epithelium and corium to corium. Use deep stay sutures of silk or fine chromic catgut, placed so that the epithelial margins appose one another with a slight up or "out-pout." When a pressure dressing is applied this will then accurately bring the epithelium to epithelium. One or two mattress end-on sutures of the type used by Blair will aid in maintaining apposition. Through the epithelium one may use interrupted 4-0 or 5-0 nylon sutures which should have one single knot with two loops, thus capable of expanding with developing edema. These should be removed within the first 48 hours to prevent stitch marks. Use fine instruments in removing them and thus avoid trauma to the skin. We prefer to use a small amount of sulfathiazol powder finely dusted in all wounds. We also use vaselined gauze on all wounds with a superimposed pressure dressing, where possible.

Nature has provided a hard long pyramid for protection of orbital structures, but severe impacts may fracture these bones with subsequent trauma to the soft tissues. Crushing injuries to the face as seen in private practice usually are unilateral and involve several structures. Almost always there will be a massive ecchymosis of the soft tissues of the eyelids and surrounding skin making examination of the eye itself difficult or almost impossible. The soft tissue edema may cover up a depression caused by fracture but palpation will confirm an interruption of the lateral wall and floor of the orbit if there is a displaced fracture of the malar bone. Crepitus and emphysema may be noted. The exact amount of displacement is confirmed by X-ray. Rotation of the ascending ramus of the zygoma if displaced downward and back is indicated if there is limitation of rotation of the eye to the affected side with accompanying diplopia and pain. The resultant blow to the eye may cause a massive intraocular hemorrhage. Where there has been a severe blow to the eyeball, the danger of retinal detachment at the time of injury or occurring sometime after the blow, has been well established. For this reason it is desirable to keep an eye subjected to severe trauma under observation at frequent intervals for several weeks.

The floor and support for the eyeball is formed mainly by the superior maxilla and malar bones. Permanent loss of this support by failure to restore these bones to their proper anatomical positions will result in a manifest hypotropia, enophthalmos, or diplopia, and may progress to a point where there is no longer sufficient protection for the cornea. Ulceration develops with possible panophthalmitis and loss of the eye. Proper alignment will make unnecessary elevation of the eyeball by cartilage implantation at a later date.

Cases are on record in which the attending surgeon has failed to diagnose serious eye injury. This can occur when it is realized that an eye can be perforated without causing the patient pain, except initially. With hemorrhage and edema of the soft tissues, minute examination is difficult and should therefore be done by a consulting ophthalmologist. Injuries causing lacerations from splintered glass may result in numerous types of eyelid injuries and even severence of the levator oculi. Early suturing of these injuries properly corrected, will save later technically difficult cosmetic repair. To prevent unsightly notching in eyelid injuries the tarsal plate and skin suturing must be offset. Tears by sharp objects through the internal canthus may divide the canaliculi and cut through the lacrimal sac. Immediate repair is desirable. Sudden blindness after a crushing injury can be due to a massive intraocular hemorrhage or a fracture in the region of the optic foramen causing a hemorrhage into the sheath of the optic nerve. Dislocation of the lens, iridodialysis, mydriasis from temporary paralysis of the third cranial nerve and other complications sometimes are seen as a result of trauma.

PRINCIPLES OF TREATMENT OF FRACTURES OF THE MAXILLA

The combined maxillae constitute a pyramidal bony buttress wedged into the anterior part of the skull base against which the lower jaw impinges, and from and to which the muscles of mastication are attached. Through it pass the upper airway to which is intercommunicated the paranasal sinuses. The orbits are protected by the bony recession in either maxilla. This bony buttress is supported or guyed by the zygoma and the orbital process of the frontal bone and that of the maxilla, all three respectively attached on either side by the malar compound.

In fracture-separation of both maxillae the face looks elongated because this buttress sinks. Usually its reapposition cannot be maintained without support to the skull. This can be accomplished

by means of an especially constructed bilateral dental bar applied to the superior alveoli, held in place by means of metal supports from a plaster head cap. An optional method is to hold the maxillae up and forward by means of drilling a small hole through the rim of the inferior orbital margin and attaching wires from this point to metal posts projecting from a plaster of paris head cap. Wire from ordinary clothes hangers can be incorporated into the plaster head cap to act as metal posts. The lower orbital margin outlines should always be restored. A head-chin bandage applied for fracture of both maxillae is not satisfactory.

In fractures of the anterior wall of the maxillary sinus and those involving the floor of the orbit it is customary to establish an antronasal window to provide drainage of blood. Through this window, by means of a curved blunt instrument such as a heavy uterine sound or urethral dilator, accompanied by external manual moulding, one may achieve reposition of the fragments. Occasionally it will be necessary to make an incision in the canine fossa to restore the fragments of the anterior wall. Again we caution against removing bony fragments unless they are totally separated, as their removal may lead to deformity. The outline of the orbital floor as aforementioned, must be restored to prevent vertical inequality of the eyes and diplopia. Either local anesthesia, block, or general anesthesia may be used.

To retain the restored outline of the fragments, one may insert a pack of iodoform gauze dipped in sulfathiazol powder, through the antronasal winddow, and leave it for four to five days. A mechanical device suggested by Doctor Shea of Memphis is simple and effective. He fastens the thumb of a rubber glove around a catheter with thread and cement, and inserts this through the antronasal window. He maintains the fragments by means of air pressure applied through the catheter.

Fractures through the malar compound frequently affect the floor of the orbit and the zygoma. Where the floor of the orbit is involved an antronasal window should be made, and manipulation through it as described above should be done. Where the floor of the orbit is not involved, the malar compound may be rotated into place by means of a very strong towel clip grasping it through the skin. Not infrequently the lateral wall of the orbit is disrupted and the lower fragment rotated inward. In some cases the above maneuver may restore it. However, in a number of cases we have had to resort to open reduction to maintain the fragments. Simply make an incision about 1.5 cm. long over the mid portion of the outer orbital rim thus exposing the fracture area. The periosteum is reflected with a thin elevator. After gently retracting the orbital contents medially, the fragments are seized with a strong forceps and the normal contour restored. Holes are drilled in the adjacent fragments and wires inserted, twisted and left outside the orbit. We have not found it necessary to remove the wire later.

Fracture of the malar compound may be replaced by the towel clamp procedure, open reduction, or more simply still by passing a uterine sound or other instrument through an incision just posterior to the third molar tooth, and up and posteriorily until it rests beneath the zygoma. The zygoma can then be pried out into position. Sometimes it is necessary to hold it out by means of a wire passed around, and fastened to a metal post issuing from a plaster head cap.

It goes without saying, that the first problem is the care of the patient. The treatment of shock, the restoration of fluid balance, and the stopping of hemorrhage should be the first considerations in all cases. The use of X-rays before and after treatment is a part of the commonsense consideration of such injuries. One must have a reasonable amount of knowledge of the anatomy and physiology of the parts involved. Along with these, and the possession of ordinary surgical principles, the treatment of wounds of these regions is not especially difficult. For the protection of the general practitioner, however, it is suggested that he secure the written opinion of the ophthalmogolist and otolaryngologist. Sequelae such as facial deformity, purulent sinusitis, exacerbation of paranasal allergy, disturbances of the bite, unaccountable pain, oseomyelitis, orbital pain, diplopia, retinal detachment and healed disfiguring cicatrices may be among those which may have been avoided by competent care at the time of the initial repair.

Blood Pressure Types

In evaluating the hypertensive patient it is important to note the different types of pressure. Simple arteriosclerosis with loss of elasticity in the arterial tree gives an elevated systolic with a normal or low diastolic reading resulting in a relatively high pulse pressure. The same type of pressure is observed in aortic stenosis and thyrotoxicosis. Differentiation of these conditions should be relatively easy. If the diastolic pressure is elevated along with systolic elevation it indicates interference with kidney function, including pyelonephritis and obstructive lesions at the bladder neck. On the contrary because of constriction in the afferent glomerular arterioles the most marked diastolic elevations are observed in essential hypertension where actual renal damage may be minimal and the kidney function relatively little impaired.—Will S. Horn, M.D., Fort Worth; Texas S. Jour. of Med., Vol. XXXIX, No. 8, December, 1943.

Foreign Body in Bronchus with Pneumothorax Occurring in Opposite Side of Chest

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THE recognition and removal of foreign bodies has become such routine matter that reports of cases of single simple foreign bodies are no longer of any special instructive value. Complications such as emphysema and atelectasis are not uncommon. However, a complication such as pneumothorax occurring on the opposite side is quite unusual and it is for this reason that the following example is being recorded. Briefly stated, it is that of an individual who had a vegetable foreign body in the left main bronchus, who successively developed emphysema and atelectasis on the same side and underwent two bronchoscopies for the removal of the foreign body which had been present for approximately one week. Following this, edema of the larynx developed and a tracheotomy was necessary. Surgical emphysema developed and a complete pneumothorax occurred on the side opposite to the foreign body. This resolved. The details of the case are reported below:

D.W.R., a white male, age two and a half years, was referred to one of us (J.M.H.) on October 14, 1941, with the history that four days before, while eating broken peanuts he was slapped by a parent, and that following this he choked and became dyspnoeic. The parent held the child's head downward and patted his back vigorously. Spasmodic bouts of coughing took place for about an hour and then ceased. Later in the day there were a few mild attacks of coughing. An acute coryza had been present for several days prior to this episode. The following day there was said to have been a high fever and the child appeared to be acutely ill but coughed only slightly. On the evening of the second day the temperature was as great as 105°. (More severe coughing developed on the third day of the illness and dyspnoea was present). The child was listless and refused food throughout. Two physicians who were consulted, did not suggest the possibility of a pulmonary foreign body. The temperature again approached 105° in the evening.

The past history was essentially negative and the family history was irrelevant. When the child was examined in the office he was acutely ill, irritable, and dehydrated. The essential positive physical findings were as follows: The respirations were rapid; there was limited excursion of the left side of the chest; no retractions could be seen. There was normal resonance. The breath sounds were suppressed over the entire left side of the chest, especially anteriorly and over the base. There were no rales. The trachea was in the midline and there was no clinically demonstrable shift of the mediastinum. The rectal temperature was 104.4° F. The pulse was too rapid to be counted. The clinical impression was that the patient had a foreign body in the left main bronchus. The chest film was reported thus: "Right side: no infiltration visualized. Left side: large area of infiltration extending from the hilus into the upper lobe. The base shows hyperaeration. The heart and mediastinum appear to be slightly displaced to the right. Diaphragms normal in position and contour. Direct left lateral view shows hyperaeration in the posterior portion of the base. There is no evidence of opaque foreign body. Impression: Non-opaque foreign body in the left bronchus with associated pneumonitis".

Exploratory bronchoscopy was deferred for further observation because one of us (R.S.R.) was not sure that a primary pneumonic process was not present. Supporting and symptomatic therapy, plus the administration of sulfathiazol were instituted. Concerning chest films made 17 hours later on October 15, 1941, it was stated that "in comparison with examination made previously, the left base showed very marked emphysema, otherwise, no change. Impression: Foreign body in the left bronchus with obstructive emphysema in the lower lobe, partial atelectasis in the upper lobe and moderate displacement of the heart and mediastinum to the right."

The chest signs at this time were: Intercostal retractions on inspiration were present on the left side with some increase in tactile fremitus, especially at the left base. The heart dullness extended about 2 cms. to the right. There was a moderate dullness in the upper left anterior portion with some hyper-resonance at the base. Breath sounds were markedly diminished over the entire left and particularly in the upper lobe at the base. The expiratory phase was extremely short. The right side was normal.

There seemed to be no question about the presence of a foreign body at this time, so a bronchoscopy was planned. The rectal temperature just prior to this was 99° F. The red blood cells numbered 4,550,000; the hemoglobin was 92 per

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cent the leukocytes numbered 23,700, the differential count being: stabs 15, segmented polymorphonuclear leukocytes 45, small lymphocytes 28, large lymphocytes 9, monocytes 2, and eosinophiles 1.

The first bronchoscopy was performed on October 15, 1941 using local anesthesia. A 5 mm. Jackson bronochoscope was used. A firm granular gray mass was found to be impacted in the lower portion of the left main bronchus. This could not be removed with appropriate manipulation lasting 15 minutes, and the bronchoscope was withdrawn with the intention of repeating the procedure later.

Coughing and dyspnoea with respirations 40 to 56 per minute continued the following day, October 16, 1941. There was some hoarseness. Intercostal retractions were noted. There was dullness over the entire left side of the chest with markedly suppressed to absent breath sounds. There was faintly heard tubular breathing near the midline over the upper left lobe. Percussion yielded a tympanitic note over the right chest with normal breath sounds. The roentgenograms of the chest were reported as showing dense cloudiness throughout the left side obscuring completely the lung markings, heart and diaphragm, The right side presented signs of marked hyperaeration. The heart and mediastinum were completely displaced to the left. The right side of the diaphragm was slightly flattened and smooth in contour. The radiologist's impression was "complete obstruction of the left main bronchus, manifested by complete atelectasis of the left lung, complete shifting of the heart and mediastinum to the left and compensatory emphysema of the entire right lung." The clinical impression was that the emphysema of the left lung had been replaced by atelectasis.

Thirty hours after the first bronchoscopy, a second one was done, on October 16, 1941 using ether anesthesia. A well-formed adherent, resilient, gray plug of blood-stained fibrin was encountered at the point of obstruction of the left main bronchus and was removed with forceps. A small amount of cloudy fluid peripheral to this was aspirated. There was considerable edema of the bronchial mucosa at this point, and some fibrino-purulent exudate was present. A slightly softened half peanut was removed and beyond this a large piece of another half. Two pinhead sized fragments were also seen, but these could not be recovered with the forceps. Within a few minutes air could be heard passing into some of the atelectic lung. Several hours after the bronchoscopy it was noted that the breath sounds in the left chest were still suppressed but that the dullness had disappeared.

X-rays on October 17, 1941 were reported as showing "the lung fields clear on either side. Heart and mediastinum very slightly, if any, displaced to the left. Diaphragms normal in position and contour. In comparison with the previous examination. the left lung has completely reaerated and the heart is assuming its normal shape and position." On October 18, 1941 the temperature became normal. However, glottic edema had gradually been developing some several hours after the second bronchoscopy. The signs suggesting tracheotomy appeared, viz., suprasternal and clavicular notch retractions, intercostal retractions, hyperpnoea, tracheal tugging, cyanosis, stridor and increase of the pulse rate. This became more pronounced and a low midline tracheotomy was performed, using local anesthesia on October 18th at noon. As the trachea was incised, the child went into shock, the pulse and respirations ceased and it was only after several minutes' administration of artificial respiration and after the use of stimulants such as cormaine, adrenalin and the use of intratracheal oxygen that the patient recovered. A number 3 tracheotomy tube with a long shank was used. Inhalations were continued postoperatively.

The day after tracheotomy, viz, October 19th surgical emphysema was found to extend over the chest, neck, back, and face.

At this time the left chest was aerating and while there was no dullness over it, there were many mucous rales throughout both lungs. There was no tubular breathing.

On October 20, 1941 the radiology department stated that "a tracheotomy tube is visualized in situ. There is a very extensive subcutaneous emphysema present from the neck down to the abdomen on either side, with pneumothorax on the right side, the upper lobe being compressed at least 60 per cent. The heart and mediastinum are displaced to the left and a patch of increased density is visualized through the heart shadow due to atelectasis or patch of pneumonia. The above-mentioned pneumothorax is undoubtedly extra-pleura caused by the subcutaneous emphysema dissecting the parietal leaf of pleura. Impression: Tracheotomy with extensve subcutaneous emphysema, extrapleural pneumothorax on the right side with compression of the upper lobe and possible pneumonitis, left base." On this date the breath sounds were noted to be more subdued over the right chest and the expiratory phase was short in some areas absent in others. From this time on until the discharge of the patient from the hospital on November 1st, 1941 the cough diminished, the respirations became less and less rapid and the pulse slower. The tracheotomy tube was gradually obstructed, and then removed. The surgical emphysema had also practically disappeared.

X-rays of October 30, 1941 were reported as follows: "Lung field again clear. Heart and aorta within normal limits. Diaphragms normal in position and contour. In comparison with film taken October 20, 1941, the subcutaneous emphysema has completely disappeared, the right upper lobe has completely re-expanded and the heart and mediastinum assumed again normal shape and position.'

On November 21st, 1941 the radiologist stated that both lungs look fairly normal. On December 5th a re-examination by X-ray was reported as "Lateral view made of the chest to complete the examination. No new information gained. The lungs appear normal."

Throughout the hospital stay eight blood counts were made. The greatest total leukocyte count was 27,000 and the least was 11,900. The stab forms varied from 23 per cent in the most toxic stage, to a low normal value of four at the time of the dismissal. The urinalyses were essentially negative, as was the remainder of the laboratory work. The pathologist's report of the plug removed from the left main bronchus at the time of the second bronchoscopy was "There is a fibrinous web heavily infiltrated with polymorphonuclear leukocytes. Some red blood cells are also present.

DISCUSSION

In examining the Cumulative Index for citations regarding cases of foreign bodies associated with pneumothorax, one is impressed with the sparse-

ness of such cases. Cantorne[1] described a case in 1938 of an 11 year old girl who had a bronchial foreign body on the right side which was accompanied by cough and dyspnoea. X-ray examination showed signs of a right pneumothorax. Repeated X-rays, the following day, were said to have showed signs of an atlectasis. Bronchoscopy failed to reveal a foreign body. Following the bronchoscopy cough diminished and clinical and X-ray examination showed signs of subsidence of a pneumothorax. On the fifth day following the first observation she coughed up a foreign body 12 millimeters long. Following this her retrosternal pain diminished and the pneumothorax was said to have been obliterated. We are not entirely convinced that a pneumothorax was present.

Seydell[2] in 1937 reported the curious condition of a foreign body aspirated into the bronchi passing through the lung and into the pleural cavity, through the chest wall under the skin. In his eleven cases of this type there was no mention of a pneumothorax.

SUBCUTANEOUS EMPHYSEMA

In 1938 a case of subcutaneuos emphysema occurring in the course of a foreign body in the bronchus was reported by Daily[3]. He thought that this emphysema developed because of a tearing of the bronchus mucosa, resulting in an interstitial emphysema which became generalized. It is probable that if there was an interstitial emphysema in his case, that it could have formed a subpleural bleb, which, if it had been ruptured could have given rise to a pneumothorax. This is mentioned because there are two possible mechanisms in the development of the pneumothorax in our case. The first is that the surgical emphysema may have developed from the tracheotomy wound. Such cases have been mentioned by W. L. Simpson[4] in 1937 who stated that emphysema may occur following a tracheotomy and that the emphysema may go into the mediastinum and rarely into the pleural cavity. Simpson mentioned that Kahler[5] had found only two instances of perforation from bronchoscopy. Imperatori[6] mentioned the possibility of pneumothorax complicating tracheotomy. Iglauer[7] reported such a case. In Simpson's paper he refers to Myerson[8] in which he reports a case of "bilateral pneumothorax and tracheotomy", and Iglauer, a case of "pneumothorax complicating tracheotomy". Simpson also refers to an article by Wiethe[9] who had two cases of pneumothorax connected with tracheotomy, and in connection with their discussion stated that when the head is markedly retroflexed the pleural domes are higher than usual and that they may be injured. Simpson's paper primarily concerns the case of a 14 month old child who was bronchoscoped about 50 times in six days because of crusts occurring in the tracheobronchial tree. Pneumothorax began to develop after the first bronchoscopy and began to clear up at the end of three days. The second possibility is that a pneumothorax could develop, as was first mentioned above, from a rupturing bleb occurring in the course of emphysema.

Neffson[10] in reviewing 126 consecutive cases of tracheotomy performed for relief of nondiphtheritic laryngeal obstruction, at the Willard Parker Hospital, found that 13.5 per cent developed pneumothorax. In eight of these 17 cases the pneumothorax was unilateral, and in nine it was bilateral. In two cases, signs of madiastinal emphysema were noted before the trachea was incised, and also in these the pleura was seen to be extruding into the wound with expiration. In five cases autopsied within 48 hours after tracheotomy mediastinal emphysema was found in three cases. In two of these, there were air blebs which could be punctured individually. In discussing the complications of tracheotomy he believed that pneumothorax and mediastinal emphysema can be prevented by, a. Eliminating respiratory obstruction during operation (e.g. doing the tracheotomy with a bronchoscope or Mosher "life saver' in place), b. Avoiding postoperative obstruction (hygiene of the tracheotomy tube), c. Avoiding the cervico-mediastinal fascial avenues, and the use of packing around the tracheotomy tube.

In our case it does not seem probable that the pneumothorax on the right side developed as a result of the foreign body in the left main bronchus. It is possible that a pulmonic emphysema could have developed in the left side. engaged the tissues of the mediastinum and later appeared on the right side causing a subpleural bleb present there. With the rupture of such a bleb, a pneumothorax could have developed. The fact that the pneumothorax made its appearance after the surgical emphysema which in turn developed after the tracheotomy, makes it seem more plausible that the tracheotomy was the exciting factor in the emphysema, and that the emphysema in turn gave rise to the pneumothorax. The latter event could have happened in two ways. First, the surgical emphysema could have dissected down the chest wall elevating the parietal pleura and in turn could have caused this to rupture. The second is that the surgical emphysema engaged the mediastinal facia and produced an intrapulmonic dissection of tissues causing rupture of the visceral pleura. One could only speculate as to which of these two mechanisms was involved. However, as has been frequently noted in autopsies, the visceral pleura is more firmly attached to the underlying structures than the parietal pleura and therefore, it seems

more probable that the parietal pleura was dissected from the chest wall and ruptured.

In the above connection J. H. Fisher and C. C. Macklin[11] in a recent paper described a fatal case in which pulmonic interstitial and mediastinal emphysema occurred in a child who aspirated peanut fragments into the right main bronchus. At the autopsy there were air bubbles in the mediastinum and there was collapse of the right lung. There was emphysema of the mediastinum and also radicular subpleural emphysema. There was emphysema in the chest and superior mediastinum and along the course of the great vessel into the root of the neck. There also was air in the perivascular connective tissues around the left lung with the formation of a large bleb under the pleura..

The author stated that the "bleb formed did not rupture, if it had done so, pneumothorax would have resulted." They think that in their case the atelectasis of the right lung caused the mediastinum to shift to the right and that the overinflation of the left lung strained the alveoli so that multiple ruptures occurred in them, allowing the air to leak into the sheaths of the finer lung vessels and thus formed an intrapulmonic emphysema with the result that the air tracked back along the perivascular sheaths to the mediastinum and along the course of the great vessels into the neck. In this respect it is noteworthy that air bubbles were found by the surgeon doing the tracheotomy. They found that there was some backing up of air into the right hilus from the mediastinum and felt that this originated from the emphysema of the left lung. In their discussion on the subject of intrapulmonic emphysema they thought coughing faciliated leakage of air to the sheaths.

CONCLUSION

The case of a child with a vegetable foreign body in the left bronchus, and the subsequent devopment of a pneumothorax on the opposite side, following tracheotomy, has been presented.

The possible mechanism for the development of pneumothorax in cases of bronchial foreign body have been reviewed. These are, viz., a. Trauma of the bronchial mucosa with resulting intrapulmonic interstitial emphysema which may give rise to a visceral subpleural bleb which could release itself into the pleural cavity. b. Dissecting extrapleural pneumothorax with formation of a parietal subpleural bleb with rupture into the pleural cavity. c. Rupture of primary pulmonary coalesced alveoli, the results of foreign body emphysema, with dissection of interstitial pulmonic tissues to give rise to a visceral subpleural bleb. d. The possibility of injury of the pleural dome in performing a tracheotomy with hyperextension of the head.

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Disparity in Blood Pressures

Blood pressure disparities between both arms are common findings, occurring in 76.4 per cent of 1,000 apparent normals and 89.3 per cent of 272 hypertensives.

The right brachial systolic blood pressure was higher than the left in 70 per cent of normals and in 84.4 per cent of hypertensives. In only 6.4 per cent of normals and 4.9 per cent of hypertensives was the left brachial systolic pressure higher than the right.

In the small number of cases in which the left brachial systolic pressure was greater than that of the right, the degree of disparity was invariably a small one.

Similarly, diastolic blood pressure disparities occurred in normals and hypertensives, but to a much lesser degree than systolic differences.

These blood pressure disparities were found in both sexes and in all adult age groups, with a tendency toward a slightly greater increment in each successive decade.

Significant and at times amazing systolic pressure disparities between both arms are common findings in apparent normals and hypertensives, and should dispel the long-standing clinical fallacy of regarding such differences as strongly indicative of aortic aneurysm.

The cause for such blood pressure disparities between both arms in normal individuals is usually inherent in the anatomy and dynamics of the aortic arch and its branches.—Bernard Amsterdam, M.D., and Alton L. Amsterdam, M.D., New York City; N. Y. State Jour. of Med., Vol. 43, No. 23, December 1, 1943.

Human Ovulation

KELLEY HALE, M.D.

A FEW years ago I heard Dr. Emil Novak of Johns Hopkins talk before the physicians of Dayton on the endocrinology of gynecology. He devoted the first half hour of his talk to reviewing briefly the physiology of the ovary, pituitary gland, uterine mucosa and their interdependent hormones producing the so-called cycle of ovulation and menstruation.

From his first statement it seems that every medical audience must be prepared by this progestional talk in order to understand the import and practical application of his excellent lecture. Before a group of pure scientists this would be unnecessary.

Due to the fine and stimulating influence of Dr. E. P. Lyons upon me as a student and assistant, I have continued to be interested in the normal structure and function of the human body while engaged in the study and treatment of diseased bodies.

Many years ago when ovulation was supposed to occur normally at the time of menstruation, I soon observed in patients suffering with appendicitis, especially of the chronic type, an enlargement and tenderness of one or both ovaries. I started a study of this problem by making a midline incision thus enabling me to palpate and inspect both ovaries at the time of appendectomy.

I took advantage of this opportunity to study the problem of human ovulation first hand. One of the first patients was a menstruating woman and I looked forward to seeing a ripe Graafian follicle as described to me once by that pioneer gynecologist, the late Rufus B. Hall of Cincinnati, Ohio. Well, I saw the ripe follicle. It was about one hundred times larger and redder than I anticipated. The ovary was much too large so I did a plastic operation removing the follicle. A glance at the section showed me that I had removed a corpus luteum.

It was not long until I had proved to myself and assistants that ovulation takes place in most cases about midway between two menstrual periods. I have continued to observe and record our findings to the present.

In 1928 I published a paper entitled "The Etiological Relationship between Chronic Appendicitis and the Small Cystic Ovary" representing a study made upon 256 women. In more than 70 per cent of patients, one or both ovaries were affected by small atretic follicles, the right ovary four times more often than the left ovary.

Submitted September 10, 1943.

The Author

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I did plastic operations upon larger ovaries that were not amenable to puncture treatment. This has provided me with a considerable amount of valuable ovarian tissue for study.

Miss K. Williams, technician, has laboriously made serial sections of much of this material. Frozen or collodion sections were made and placed in petri dishes and by using a binocular dissecting microscope, the desired sections containing ova in different stages of development, corpus luteum, corpus albicans, etc., were selected for staining and permanent mounts. The unstained sections were preserved in good sized bottles of preservative fluid.

I have reviewed all my sections recently, also the medical literature on ovulation for the past ten years that we have in our library. As a general statement, I think I have enough slides to prove or disprove any assertion that I have seen in the literature pertaining to human ovulation.

It is most difficult to obtain normal human ovarian tissue for study. All our tissues had been influenced by chronic appendicitis or other disease. The diseased appendix we know often produces a thick, toughened cortex that is probably responsible for many small cysts of the ovary and possibly a few cases of sterility. I have seen conception occur in apparently sterile women following appendectomy and plastic work upon the ovaries. On the whole, however, it is not difficult to find a corpus luteum or its remains.

The age of the menstruating patient generally can be estimated broadly from the sections into early, middle or late menstrual life by the number of primordial follicles present, the size and appearance of the corpus luteum and the number of corpus albicans present. In late menstrual life the latter appear more abundant as many as eight or ten being noted in one section. Primordial follicles are more abundant in early menstrual life and seem to disappear more or less rapidly to the menopause.

More mature ova are found in young women. Two or more ripe follicles have been observed in a small segment of ovary together with a number of larger atretic follicles or small cysts.

We have noted that ovulation takes place before and after menstrual life. A corpus luteum was found in an ovary after the menopause.

I have never noted a ripe corpus luteum midway between two periods. It is impossible for me to distinguish at the operating table between a ripe Graafian follicle and an atretic follicle of the same size.

The marching and halting army of 35,000 primordial follicles responding to the orders of the corpus luteum and anterior pituitary hormones certainly exert a considerable influence on the menstrual cycle perhaps in giving orders to the sex centers of the brain to get busy.

The most important phase of this subject has been ignored probably because of delicacy, privacy and extremely personal nature of sex physiology. The males of all species are much alike in this respect, always ready. Woman and monkey are generally quite masculine in this respect.

The destruction of the function of ovulation by radiation does not destroy the physiology of libido which then must depend upon a hormone of the ovarian stroma. A definite general bodily sex cycle has been observed in women following radiation of the ovaries.

The phenomenon of orgasm of the female was not intended, I believe just for her pleasure alone but as in the male, a mechanism for the extrusion and moving along of her germ cell or cells. In other words the ovary attempts to extrude a ripe ovule if present at the time of coitus regardless of the phase of the menstrual cycle.

In closing I want to pay tribute to one of the greatest physiologists, a man so great and advanced that it has taken thousands of years to catch up with him. His name is Moses.

The Jews have a religious law called going to Mickwie which should have excited the attention of doctors long ago for without intending to do so, clearly places the beginning of ovulation thirteen days following the first day of menstruation.

The following words are found in the fifteenth chapter of Leviticus: "And if a woman have an issue and her issue in her flesh be blood, she shall be put apart seven days; and whoever toucheth her shall be unclean until the even. But if she be cleansed of her issue, then she shall number to herself seven days and after that she shall be clean. And on the eighth day she shall take unto two turtles or two young pigeons and bring them unto a priest, to the door of the tabernacle of the congregation."

1. Annals of Surgery, December, 1828.

Value of Studies of the Circulation

Study of the circulation, using the simple tools of a stethoscope, a sphygmomanometer, a watch and your five senses can, therefore, not only be extremely useful in diagnosis, but invaluable in following the trend of your patient's condition under your therapy, or under your operation, and can even assist in prognosis.

We might go further and suggest that a careful study of circulation in all cases might prevent deaths in patients who, by all other tests, appear to be progressing well. We were reminded of this possibility a few months ago, while attending a hospital staff meeting. One of the subjects for discussion was diabetes. Three patients were mentioned, two of whom died suddenly. All three, including those who died, had attained the admirable condition, the acme of perfection in treatment, normal blood sugar, and no sugar in the urine. Nevertheless, two of them were dead. Why do diabetic patients die? In the one case, the patient had been so well after a few days of treatment that he was allowed to sit up in bed. He apparently died from acute embolus, which might well have arisen from an inadequate circulation. The second quite probably died from circulatory failure. Diabetic patients do not die because their blood sugar is high, or their urinary sugar is high. They die because, as part of the picture of improper sugar metabolism, poisonous chemicals are produced, for betabutyric acid and acetone are both narcotics. We know that these compounds affect circulation seriously, and that the impairment of circulation might still be present, even when biochemical tests for them are negative. Any physical load suddenly placed upon such a defective circulation can lead to an acute collapse and death. The same mechanism can occur in other diseases for we only die when both circulation and respiration fail.

If we know as much as possible about the circulation of each of our patients we are more prepared to combat serious collapse. Proper rest in the correct position, or inhalation of oxygen, or, in some cases, adequate nutrition or therapy, might maintain life sufficiently long to allow remedy of the condition for which the patient came under our care.—John H. Foulger, M.D., Wilmington, Del.; Del. S. M. Jour., Vol. 15, No. 10, October, 1943.

Thrombocytopenia Purpura Associated With Exophthalmic Goiter

A Review of the Available Literature and a Case Report

STANLEY D. CONKLIN, M.D. and PAUL J. SHANK, M.D.

THROMBOCYTOPENIC purpura is a rare disease and perhaps of sufficient interest to warrant a case report. A review of the available literature discloses only five reported cases in which this disease has been associated with exophthalmic goiter. Jackson[1] has reported a case in which the hemorrhagica purpura began after the administration of iodine to control the hyperthyroidism. This patient must be placed in the symptomatic class of thrombocytopenic purpura as she made an uneventful recovery after the thyroidectomy and cessation of the iodine.

Bickel and Dicker[2] have reported two cases of hemorrhagic diathesis in patients with exophthalmic goiter, who presented extensive involvement of the skin, mucous membranes and recurring visceral hemorrhage. This type of hemorrhagic diathesis is observed exclusively in the grave and acute forms of hyperthyroidism, and is the result of multiple factors, among which is secondary hepatic insufficiency. The liver insufficiency prevents the normal utilization of vitamin K by the liver and causes severe hemorrhages analogous to those observed in yellow atrophy of the liver and in certain forms of icterus and of hepatic cirrhosis. The authors also believe that the capillary fragility and vitamin C deficit frequently noted in these patients likewise play a part in the pathogenesis of certain simple purpuras in exophthalmic goiter. However, the administration of vitamins K and C will result in a relative amelioration, since there is not a real deficit but rather an impairment of its utilization by the damaged hepatic parenchyma. For this reason, treatment of the hyperthyroidism is the only method to obtain a permanent cure of this hemorrhagic diathesis.

Finochietto, del Castillo and Parodi[3] have also reported one case of exophthalmic goiter and thrombocytopenia purpura. Laignel-Lavastine and Cachin[4] reported a patient who had an exophthalmic goiter with an associated purpura. This patient developed a double hemiplegia.

Thrombocytopenia purpura is classified into two groups, the idiopathic and symptomatic. The successful management of the former often requires life-saving surgery, while the latter must be treated by medical means. This disease may be acute or chronic characterized by a marked decrease in the number of blood platelets, spontaneous hemorrhages from the mucous membranes and purpura. The blood platelets are greatly reduced from the normal of 300,000 to 400,000 to less than 100,000, and in acute cases to even less than 20,000. If the blood vessels are injured in a case of thrombocytopenic purpura, the effused blood clots but the clots do not contract. Thrombosis does not take place readily in the injured vessels and the bleeding time is greatly prolonged. The tourniquet test is present in most of these cases but should not be relied upon.

In 1775, Werlhof[5] first described this disease and established it as a distinct clinical entity. In 1916, Kaznelson[6] performed the first splenectomy for chronic hemorrhagic purpura.

Wiseman, Doan and Wilson[7] have given diagnostic essentials for an accurate diagnosis of idiopathic or essential cases of thrombocytopenic purpura. They are:

1. There must be spontaneous purpura and/or free bleeding from the mucous membranes.
2. The blood platelets must be substantially decreased in numbers, less than 100,000 per cubic millimeter of blood.
3. The clotting time and prothrombin time must be within normal limits.
4. The anemia and leukocyte count must not be out of proportion to the amount of bleeding.

The Authors

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Submitted October 29, 1943.

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**Former Fellow in Surgery at Guthrie Clinic, Sayre, Penna.

5. There must be no pathologic cells in either the blood or the bone marrow.

6. There must be no recent history of the ingestion of drugs or the occurrence of those diseases known occasionally to produce thrombocytopenia.

7. There must be no appreciable enlargement of the spleen or lymph nodes.

CASE REPORT

A white woman, aged 36 years, was admitted to the Guthrie Clinic and Robert Packer Hospital October 11, 1942, for marked shortness of breath which had been present for the preceding five years and which was becoming increasingly worse, and the coughing up of about one-half cup of blood the night before her admission. She became so weak that she was unable to walk to the bathroom. She stated she was always tired and fatigued very easily. She had a marked palpitation of her heart. Her legs were swollen the week before her arrival. She was very nervous and cried frequently. She had lost about 15 pounds in weight in the preceding few months in spite of a good appetite. She had frequent night sweats. Menses began at 13 years of age, were regular every 28 days, lasting four to five days. However, during the preceding nine months they had been irregular and the last period was in June, 1942. She had one living child.

A physical examination revealed an anxious white female who showed the results of hemorrhage and recent loss of weight. She had a marked exopthalmos of both eyes with a more or less fixed stare. Some purpuric spots were seen on the ears. The nose contained old clotted blood and petechial hemorrhages of the mucous membranes. The soft palate and the pharynx revealed purpuric spots. The thyroid was diffusely enlarged and pulsating, with marked engorgement of the veins of the neck. The heart was enlarged to the anterior axillary line and quite irregular in rate and rhythm. Some moist crepitant rales were heard in both lung bases. The liver was enlarged to four finger breadths below the costal margin, and pitting edema of the lower extremities was present. The skin was moist. Blood pressure was 136 systolic and 98 diastolic with a positive tourniquet test.

It was evident this patient was in a critical condition suffering from a hyperthyroidism and some type of blood dyscrasia. The patient was too ill for us to determine the metabolism on admission and on October 23, 1942, the basal metabolic rate was plus 52 per cent, the weight 98¾ pounds and the pulse rate 120. Hemoglobin was 28 per cent, erythrocytes numbered 1,740,000 and leukocytes 4,100, polymorphonuclear leukocytes 82, lymphocytes 18, on October 11, 1942. The Kahn test was negative. Blood culture was negative. Prothrombin time was 50 seconds for the patient, with a control of 40 seconds. On October 14, 1942, the blood platelets were 32,000 and dropped to 28,000 eight days later. The patient received two blood transfusions and the hemoglobin rose to 42 per cent, with 2,680,000 erythrocytes. On November 2, 1942, the platelet count was 54,000 but fell to 8,000 ten days later. The platelet count rose to 14,000 on November 23, 1942.

During this time the patient responded to her lugolization and her basal metabolic rate was as follows:

Date	Basal Metabolic Rate	Weight
10/23/42	Plus 52	98¾ pounds
10/28/42	Plus 40	99 pounds
11/ 4/42	Plus 43	100½ pounds
11/23/42	Plus 32	101¾ pounds
12/ 5/42	Plus 45	104 pounds
12/ 8/42	Plus 51	106½ pounds

The careful observation of this patient convinced us she was no candidate for surgery. Deep roentgen therapy was advised and she received nine treatments over her thyroid gland. The patient made a satisfactory improvement following the roentgen therapy. Her hyperthyroidism had improved and she apparently was in a state of remission as far as her thrombocytopenia purpura was concerned. She was discharged and instructed to return for a check-up, which she did five weeks later. At this time her blood platelets were 16,000, coagulation time four minutes, bleeding time two minutes and no clot retraction. The hemoglobin was 48 per cent with 3,480,000 erythrocytes. Basal metabolic rate was plus 50 per cent, weight 112½ pounds and a pulse of 94 beats per minute.

It was decided to do a ligation of both poles of the thyroid. On February 4, 1943, the right pole was ligated without any difficulty, but, on attempting to ligate the left pole, uncontrollable hemorrhage was encountered and a complete lobectomy was necessary to control this hermorrhage. The left lobe was the larger of the two. The patient made the usual postoperative convalescence following a thyroidectomy and had no postoperative bleeding, the wound healing per primum. The patient was discharged 16 days after her operation. She returned six weeks later weighing 131 pounds and had a blood pressure of 138 systolic and 88 diastolic. She stated that she had never felt better in her life and had had no attacks of bleeding. Blood platelets at this time were 30,000; hemoglobin 71 per cent, erythrocytes 3,400,000, leukocytes 7,300 and a differential count of 78 polymorphonuclear cells and 22 lymphocytes.

COMMENT

This patient answered all of the prerequisites for the essential thrombocytopenic purpura class except for the fact that no bone marrow studies were made. However, no pathologic cells were found in the blood.

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Dolorimetry

A Quantitative Method of Measuring Pain and Deep Sensibility

L. J. B. GLUZEK, M.D.

PAIN is the most compelling and vivid of all human symptoms but because it is so exquisitely subjective, it is an extremely elusive phenomenon and difficult to reduce to quantitative terms. Many attempts have been made to determine normal human sensitivity to pain, none of which are fully satisfactory, and most of them have dealt with little more than measurements of skin sensation alone. Libman's[1] method, a rough but practical one, utilized pressure over the mastoid and a gradation of three sensitivities was arbitrarily noted. The newer techniques such as those of Hurst,[2] and Hardy, Woolf, and Goodell[3] are excellent but require an elaborate apparatus and are not readily adaptable to the clinic or the bed-side.

Excluding the superficial skin sensations, dolorimetry deals with deep pain, and for the sake of convenience, it includes all painful experiences arising from the viscera, from the deep muscles and from nerve trunk irritation.

In order to determine an individual's natural pain sensitivity, or, in other words, the pain threshold, it is necessary to administer stimuli of a certain density and increase their strength gradually until the impulses so created reach the thalamus with sufficient force to act as a pain-impact. Somewhere in the lateral nuclear mass of the thalamus, this pain-impact is transferred by way of the thalamo-cortical tracts to the post-rolandic gray matter, where it is consciously perceived as pain sensation.

The dolorimeter is a small compact and relatively simple apparatus (Fig. 1) which can be easily carried to the bed-side or quickly applied to the patient in the consulting room.

THE TECHNIQUE OF DOLORIMETRY

To measure the pain-threshold, the instrument is applied to the flat surface of the middle third of the tibia. The patient's leg is placed on the leg rest and the double pressure apparatus, with its pressing surface, is lightly adjusted to the bone. It is fixed in this position by tightening the universal screw (S). The needle valves are closed.

In the first part of the procedure, the inductor is applied with gradually increasing pressure upon the bone. This consists of a standard pressing surface—a disc 9 mm. in diameter which is found in the center of the double pressure apparatus. This inductor is forced downward on the tibial surface by pumping air with the pump (P_1) through the air chamber by way of a tube (T_1) while the pressure is registered by the gauge (G_1). This pressure should be read as soon as the patient indicates that he senses mild pain. This reading is the tension value of the patient's pain-threshold, if the level has been confirmed by the second part of the test.

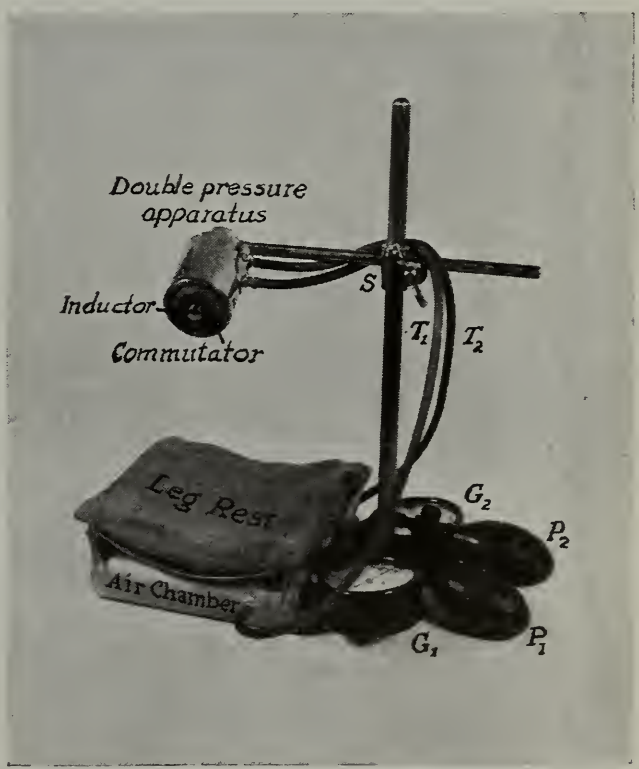


Fig. 1. The Dolorimeter showing the essential mechanical parts.

The second phase of the test consists of trans-

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The Author:

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ferring the inductor's pressure to a surface ten times as large, namely to the commutator, a rubber disc which completely surrounds the inductor, thereby lessening the density of the stimuli, and eventually removing them entirely by lifting the inductor. This is done by pumping air at P_2. While this shift of pressure is being made, the patient is asked to indicate the moment that the inducted pain has disappeared. Air gauge (G_2) is read at the point when the patient indicates relief. When the valve of the commutator is then opened and the commutator pressure drops, the previous pressure imposed by the inductor becomes reestablished. The patient will then say "now it hurts again." This pain experience will be announced at the same pressure reading which was recorded by the first part of the test.

RESULTS

In more than sixteen thousand readings, this test has given reliable and useful information. The normal range of the pain-threshold was found to be from 500 to 2700 g. The age of the persons tested ranged from 6 to 82 years. Most individuals were found to have a fairly stable pain-threshold.

If a patient complains of a pain in the course of an illness, it can be measured by administering artificial pain which is of a somewhat higher tension than his alleged pain. This is done by applying the dolorimeter on the shinbone, preferably on the pain-free side if the discomfort is unilateral.

Except in pain with very low absolute values where the rubber commutator pressure might suffice to overcome the patient's pain, such as in the neuroses, in instances where there is true organic pain, the inductor alone is applied.

Pressure by pumping air into the inductor is administered until the patient states that he feels pain in his leg. Gauge (G_1) is read and the patient is instructed to focus his attention to his original or "organic" pain wherever it may be. Then the inductor's pressure is slowly increased until the patient announces that his true pain has ceased. The pressure reading of G_1 is again noted and this is recorded as being the measure of the alleged pain. Usually this pressure exceeds the true tension value of the patient's pain by 15 per cent.

By opening the valve, the artificial pain and pressure is removed and the patient's original pain returns if it is due to an active process or to true disease.

This quantitative measurement of pain when taken from time to time in an individual case closely parallels the objective signs of disease such as fever, swelling, reflex excitability, and insomnia. In this respect it was found to be a convenient, reliable and prognostically valuable adjunct in diagnosis and treatment of nearly 97 per cent of pain entities studied over a period of several years.

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Pennicillin for Syphilis

A preliminary report on the use of penicillin in early human syphilis was given October 14 before the American Public Health Association by Senior Surgeon J. F. Mahoney, Surgeon R. C. Arnold, and Ad Harris, serologist, of the Venereal Disease Research Laboratory, U.S. Marine Hospital, Staten Island, N.Y.

After limited animal experimentation had indicated that the drug possessed definite spirocheticidal activity and was practically nontoxic, pencillin was administered to four male patients with primary syphilis by intramuscular injection. The arbitrary schedule used consisted of injection of 25,000 units of the drug at 4-hour intervals, night and day for eight days. Total number of injections was 48, total amount of drug was 1,200,000 units. The gluteal muscles were the site of injection.

After the 16th hour Spirochaeta pallida could not be demonstrated in secretions collected from the primary lesions. A comprehensive routine of serodiagnostic tests indicated that the therapy was responsible for a more or less rapid and complete disappearance from the blood stream of the reacting substance which is usually associated with activity in early syphilis. Clinical reactions to the drug were mild but definite, including general malaise, mild headache, moderate temperature elevations, and enlarged regional lymph glands. None of the symptoms were judged as representing toxic response to the drug.

The four patients will be maintained under close observation for the detection of any tendency toward a recurrence of positive serologic findings and any evidence toward clinical relapse. Effectiveness of the therapy in additional patients will be observed as soon as adequate supplies of the drug are obtainable.

In conclusion, the report stated: "Should later experience confirm the impressions to be gained from the present pilot study, a rebuilding of the entire structure of syphilis therapy may become imperative."—Military Surgeon, Dec., 1943.

Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

THE causes of hemoptysis are still not clearly understood. Blame has been laid on deficiency in one of the factors concerned in blood coagulation, on tonic, nervous or endocrine factors, on erosion of a vessel wall by a tuberculous process, on rupture of a small aneurysm within a cavity. While the most serious hemorrhages occur in old, fibroulcerative tuberculosis, small or moderate hemoptyses may be seen in early disease, sometimes as the first recognizable symptom. Softening of a lession or progression of an established process may be accompanied by hemorrhage.

Among 1,000 patients consecutively discharged from the Blue Ridge Sanatorium, Charlottesville, Virginia, only those were included in this study who gave a clear-cut history of spitting up one dram or more of blood, or who suffered a hemorrhage during their stay in the institution. "Streaking," "streaked sputum" and indefinite history of hemoptysis were excluded. In all, 905 cases of tuberculosis, made up of 424 males and 481 females, included 220 who had hemoptyses during the active phase of the disease. This is an incidence of 24.3 per cent, regardless of the duration of observation.

Some of the largest hemorrhages in this series occurred in a few patients showing bronchiectasis or rheumatic heart disease. Bogen, including instances of streaks and clots, found that over half of his hemoptysis cases expectorated less than two ounces of blood. The present study records 106 hemorrhages of stated amount, ranging from one dram to two quarts, the average being five ounces. This did not include repeated bleeding from the same individual on the same or subsequent days, since these were not felt to be distinct episodes, but more or less a continuation of the first. In approximately 40 per cent of the cases the episode of hemoptysis was repeated at least once.

Hemorrhage was the presenting symptom, often the initial evidence of trouble, in 60 cases. Perhaps nothing drives a patient to seek medical advice faster than the expectoration of a single mouthful of blood, although 23 patients did nothing about their initial hemorrhage.

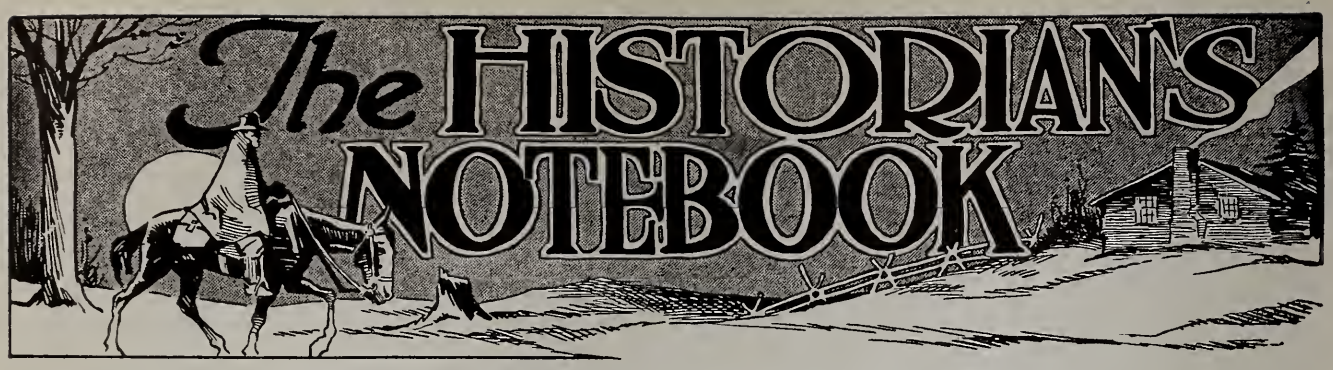
Only 49 cases in the entire hemoptysis group failed to show a cavity on X-ray examination and of these 11 were found to be nontuberculous. No less than 83.4 per cent of the tuberculous cases with hemorrhage had a positive sputum! Of the 170 patients in this latter category, 159 had roentgenograms revealing consolidation, honey-combing, punching out or frank cavitation.

Correlation of hemoptysis with physical exertion, with direct chest trauma or with mechanical disturbance of the lung is possible in some cases, though hemorrhage may and often does appear when the patient is at rest, perhaps during sleep. In only 28 cases in this study was there either a specific history of a precipitating factor or of its absence. In 10 patients hemorrhage was related to one or more menstrual periods.

Among the graver consequences of pulmonary hemorrage must be listed strangling and asphyxia from massive bleeding, fatal blood loss in the cachectic patient, and the commoner and ever-present danger that blood from a cavity which is generating a positive sputum will spread the infection to other parts of the lungs, giving rise to an acute tuberculous bronchopneumonia or a massive caseous pneumonia. Obviously, repeated episodes of blood-spitting multiply the chances for such complications to occur.

SUMMARY AND CONCLUSIONS

1. In a study of 1,000 sanatorium tuberculosis patients it was found that hemorrhages occurred in 24.3 per cent of them.
2. The average size of hemorrhage was five ounces. Forty per cent of hemorrhages were eventually repeated.
3. In 60 patients, the first remarkable symptom was hemoptysis.
4. Seventy per cent of cases with a history of hemorrhage before diagnosis were properly diagnosed by the local physician, when he was consulted. However, 13 per cent were misdiagnosed.
5. Most tuberculous patients who hemorrhage have cavitation visible on X-ray examination, 83.4 per cent of this series had a positive sputum.
6. Trauma to the chest, strenuous exercise, mechanical disturbance of the lungs and, in females, the menstrual period are definite precipitating factors.
7. Small hemorrhages often occur from early lessions at the height of the catarrhal and toxemic symptoms which probably signify softening. These are not usually serious and may, in the long run, be beneficial if they call attention to an undiagnosed tuberculosis. However, larger hemorrhages which occur in chronic ulcerative tuberculosis, while rarely immediately fatal, are accompanied by many unpleasant and dangerous possibilities. Of the 12 deaths which occurred in the sanatorium after hemoptysis, it is felt that 5 were directly or indirectly the result of the hemorrhage.—George R. Minor, M.D., American Review of Tuberculosis, August, 1943.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

An Esoteric Thompsonian Ohio Medical Periodical

ROBERT G. PATERSON, PH.D.

A FLEETING and yet unique medical periodical has been acquired recently by the Ohio Committee on Medical History and Archives. It is in the Library of Ohio State University. The title is "The Botanic Ledger and Family Journal of Health." It was established at Oxford, Ohio, by Dr. J. Bennett as Proprietor; was edited by Dr. J. Lamborn, Jr., and, printed by W. W. Bishop. The period covered by the journal was January, 1839, Volume 1, Number 1, to April 30, 1840, Volume II, Number 8. The copy acquired has an inscription—"Miriam C. Worrell from her brother, Dr. J. Lamborn."

That the publication is a rare one becomes evident when it is not to be found in the Index-Catalogue of the Army Medical Library, Union List of Serials, nor in any of the lists of Ohio Medical Journals. Dr. Claudius F. Mayer, Chief, Division of Index Catalogue and Research, Army Medical Library, says of this periodical:

"Of course you probably saw the Union List of Periodicals and must have found that none of the larger medical libraries possess any copy of the Ledger. This, however, does not mean that it is of any great value, though it seems to be a rare little quack journal."

The mast-head motto of the Ledger is interesting in the light of the foregoing comment. It was:

"The most effective way to destroy quackery is to diffuse medical knowledge among the people."

The motto was borrowed from Dr. William Buchan (1729-1805) author of Domestic Medicine, first published in England in 1778, and of which a revised edition was published at Philadelphia in 1795.

Volume I runs monthly through the year January to December, 1839, and comprises a total of 96 pages—each number containing eight pages. The price was seventy-five cents (75c) a year in advance. Volume II runs semi-monthly in the year 1840 from January to April 30, and comprises 64 pages—each number containing eight pages. The price was one dollar a year in advance. In the April 15 issue, the editor says:

"We are languishing for support, but intend to beg no more; and unless the friends of the cause do something more than has been done, they need not be surprised if the Ledger dies."

The last issue on April 30, however, gives no monitory warning of sudden death but the end of Volume II occurs on that date and on page 64.

The mast-head of the Ledger for Volume I, Number 1, January, 1839, carries J. Bennett as proprietor and J. Lamborn, Jr., as editor. On page 8 of this number there is an advertisement as follows:

"Drs. Bennett and Lamborn
Botanic Physicians
(Office—Main Street, Oxford, Ohio)

They have fitted up a private room in which they are prepared to administer the vapor bath, &c. to those who wish to be thus accommodated.

Also, genuine Botanic Medicines for sale."

With Volume I, Number 3, March, 1839, the mast-head has dropped J. Bennett as proprietor and carries over J. Lamborn, Jr., as editor, and this continues throughout Volume I. Beginning with Volume II, Number 1, January 15, 1840, the mast-head carries J. Lamborn, Jr., as editor and

The Author

● Dr. Paterson, Columbus, Ohio, is secretary, Ohio Committee on Medical History and Archives; executive secretary, Ohio Public Health Association, Columbus, Ohio.

proprietor. At the close of this number on page 8, there is a notice that:

"The firm of Drs. Bennett and Lamborn has been dissolved." It is signed by Bennett and Lamborn and dated at Oxford, December, 1839.

In announcing the platform of the Ledger it is said:

"It shall be the object of this publication to spread knowledge and facts among the people, on the subject of health and disease, and to expose all Medical Monopolies, as derogatory to their interests and happiness.

"We shall, by appealing to their judgments and common sense, endeavor to show them, on the one hand, the inconsistency and ruinous consequences of using poisonous and life-destroying agents in the cure of disease, and on the other, the innocency and beneficial results which follow the use of those innoxious vegetables *brought into notice* by Samuel Thomson. We shall denounce, as the basest species of quackery, the secret nostrumizing now so popular, as we conscienciously believe it to be the most odious imposition extant.

"In our efforts to promote reform, we shall sustain the fundamental principles of the 'American System of Modern Medicine, known by the name of Thomsonian or Botanic!'"

**Our warfare being against erroneous principles, under the garb of science, we shall pursue our course regardless of the opinions of men, or the frowns of a popular profession. Directed by the light of truth and the claims of humanity, we cast our Journal to the waves, in the hope that the surges of popular fury and prejudice may dash against her in vain."

In this same issue the intent of the editor is made clear when he wrote:

"We shall send the Ledger to those Medical Journals within our knowledge, but especially to the 'Boston Medical and Surgical' and to the 'Cincinnati Quarterly' and hope their Editors will remember us in return. We take it for granted that Drs. Smith and Drake are in favor of reform, and can say that we feel *proud of such* men.

***Dr. Drake will likewise recollect 'the day of small things.' If our Journal prospers, we venture to predict that, during 'eleven years Editorship, seventy-five per cent of the matter received' will not 'have to be revised before it is fit to go before the public.' Though it should come from those whom your profession are pleased to term "steam quacks." We heard you assert last winter, that you had to do this with matter received from your brethren. Gentlemen, we long to hail you as brothers; but if we cannot, don't be scared—our *'wormwood and gall'* shall be poured only on quacks and their quackery."

Material contained in the various numbers consisted of quotations from other Botanic journals, letters from supporters, and current comment by the Editor. Throughout the tone is militant against the "scientific M.D.'s." The climax is reached in the August, 1839, issue when the Editor wrote a long editorial attacking the medical profession in general for their stubborn opposition to the Botanic system and flaying the medical profession in particular in Oxford—singling out some five of the local physicians for special attention.

In the course of the editorial it is said:

"Having been tortured into a course of self-defence, altogether foreign from our nature, by a persecution unequalled in infamy by that waged against christianity, we are determined henceforth to deal with our opponents as Christ dealt with the Scribes and Pharisees, when he exclaimed, 'wo unto you ye generation of vipers, how can ye escape the damnation of hell.' Such severity was demanded of him, and such is equally demanded of us."

In the March, 1839, issue the editor gives a clue to his outlook and purposes when in an editorial he says:

"In using the term reform, we assure our friends, that we feel no desire to reform the old system, as we too, would just as soon think of 'transforming the devil into an archangel seraphrim,' as to endeavor to get any thing out of it as it regards curing disease, but ruin and death. We only wish to reform the world out of its darkness into the light of true Medical Science. Therefore, 'upon the second sober thought' we conclude to adopt 'revolution' as our motto in the future."

It is interesting to scan the pages of this rare curiosity in Ohio Medicine if for no other reason than to have the point impressed again that the medical journals of one hundred years ago were pugnacious. The use of robust language gives a spicy flavor to many of the otherwise prosaic and banal subjects.

Dr. Francis Reuben Woodard (1848-1926) was born in Madison, Lake County, Ohio, on July 15, 1848, the son of Joseph S. Woodard, and Frelove M. Baker Woodard. In December of 1858 his parents emigrated to the new state of Minnesota. Young Woodard had attended public schools in Painesville, Ohio; in Rochester he completed his primary education while he was assisting his father in the prescription room of the pharmacy. In 1869 he entered the University of Michigan. After an intervening period spent in Rochester he entered the University of Michigan in 1875 for the study of medicine. In 1876 he matriculated at the Rush Medical College of Chicago from which he graduated in 1876. He settled in Claremont, Dodge County, and was elected a member of the Minnesota State Medical Society on June 21, 1881.

In 1881 Dr. Woodard decided to move to Minneapolis. His practice at Claremont was taken over by Dr. Charles Sumner Bigelow, (1845-1931) whom he had known during student days at the University of Michigan. Dr. Woodard died at Saint Augustine, Florida, on March 29, 1926. He had spent 47 years in the practice of his profession. — James Eckman, Rochester, and Charles E. Bigelow, M.D., Dodge Center, Minn.; Minn. Med., Vol. 26, No. 12, December, 1943.

Proceedings of The Council

Plans for 1944 Annual Meeting, Industrial Health Meetings and Budget Approved at Meeting Held on December 12

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the State Headquarters Office, Columbus, on Sunday, December 12, 1943, with the following present: President Sherburne, President-Elect Schriver, Treasurer LeFever; Councilors Swartz, Messenger, Noble, Brindley, McNamee, Rutledge, Lincke, Swan, Micklethwaite and Knoble; Dr. Forman, Editor of *The Journal*; Executive Secretary Nelson and Assistant Secretary Saville.

On **motion** by Dr. McNamee, seconded by Dr. Knoble, and **carried**, the minutes of the meeting of The Council held on October 3, 1943, were **approved.**

Membership Statistics were reported as follows: Total membership as of December 12, 1943—6,782 (including 5, 011 paid members and 1,771 military members); compared to total membership a year ago of 6,714 (including 5,447 paid members and 1,267 military members) and total membershsip as of December 31, 1942, of 6,726 (including 5,353 paid members, and 1,373 military members.)

Members of The Council then reported on activities in and visits to county medical societies of their respective districts. Dr. Sherburne, the President, again urged members of The Council to keep in close touch with county societies and to encourage all of them to hold meetings regularly.

1944 ANNUAL MEETING

The Executive Secretary reported on plans of the Committee on Scientific Work for the 1944 Annual Meeting to be held May 2, 3, and 4 at the Neil House, Columbus. The schedule of events and program arrangements to date were **approved** on **motion** by Dr. Messenger seconded by Dr. Swan and **carried.**

On **motion** by Dr. Brindley, seconded by Dr. McNamee and **carried,** The Council **voted** to meet at 1:30 P. M. on Tuesday, May 2, immediately preceding the first session of the House of Delegates; and to hold a dinner meeting on Tuesday, May 2, at 6:00 P.M., at which Past-Presidents would be honored guests.

REPORT OF COMMITTEE ON AUDITING AND APPROPRIATIONS

In executive session The Council heard a report of the Committee on Auditing and Appropriations presented by Dr. McNamee, Chairman, and the following budget for 1944 was **adopted** on **motion** by Dr. Schriver, seconded by Dr. Brindley and **carried.**

BUDGET FOR 1944

The Ohio State Medical Journal	$11.000
Executive Secretary, Salary	6,800
Executive Secretary, Expenses	800
Asst. Exec. Secretary, Salary	5.300
Asst. Exec. Secretary, Expenses	600
Stenographers, Salaries	4,620
President, Expense	500
Council, Expense	900
Committee on Public Relations	6,000
Committee on Education	600
War Participation Committee	500
Miscellaneous Committee Expense	200
Committee on Industrial Health	800
Stationery and Supplies	1,200
Postage, Telephone and Telegraph	2,300
Rent, Insurance, Bonding	2,800
Auditing and Appropriations Committee	100
Annual Meeting	3,800
A.M.A. Delegates, Expense	300
Total	$49,120

On **motion** by Dr. Noble, seconded by Dr. Micklethwaite and **carried,** it was **voted** to enter into a three-year lease for the present quarters of the State Association at an annual rental of $2,400.

REPORT OF COMMITTEE ON PUBLIC RELATIONS AND ECONOMICS

Minutes of the meeting of the Committee on Public Relations and Economics held October 23, 1943, were reviewed and the report of the committee was **approved,** on **motion** by Dr. McNamee, seconded by Dr. Brindley and **carried,** including a recommendation of the committee that the State Association should not establish a loan fund for physicians separated from military service because such a program would be impractical and involve the establishment of machinery beyond the resources and facilities of the Association.

Mr. Saville, Asst. Executive Secretary, explained in detail the program being carried on in opposition to the Wagner-Murray-Dingell Bill. He reported that as of that date approximately 150,000 pamphlets had been distributed and that a second edition of the pamplets would be published in order to meet pending orders. On **motion** by Dr. Knoble, seconded by Dr. McNamee

and carried, this work of the committee was approved and the committee thanked for its excellent job.

REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

The Executive Secretary reported on a meeting of the Committee on Industrial Health held in Columbus on October 24, 1943. Plans for a series of Industrial Health Meetings to be held on February 7, 8, 9, and 10, in Toledo, Cleveland, Columbus, and Cincinnati, respectively, were approved, on motion by Dr. McNamee, seconded by Dr. Brindley and carried. (See pages 57-59, this issue of *The Journal*.)

DEVELOPMENTS ON MEDICAL SERVICE PLANS

There was a general discussion of recent developments with respect to creation of medical service plans under the Ohio Enabling Act. It was stated that revived activity is taking place in Cincinnati, Youngstown, and Toledo.

Reference was made to the action of The Council on July 11, 1943, offering to assist the Logan County Medical Society financially and otherwise in establishing a medical service plan in Logan County under the Enabling Act, providing the Logan County Medical Society desired such assistance and wanted to proceed with such activity. The following resolution, adopted by the Logan County Medical Society on October 15, 1943, was read:

"That the Logan County Medical Society thoroughly approves, in principle, the plan offered by the Ohio State Medical Assaciation in reference to an Incorporated Medical Service Plan as defined by the Enabling Act (House Bill No. 51), subject to the following provisions:

"That the Logan County Medical Society defer final vote for execution of the above described plan for six months in order to permit futher study by the Logan County Medical Society and the Ohio State Medical Association."

On motion by Dr. Schriver, seconded by Dr. Knoble, and carried the Executive Secretary was instructed to write the Logan County Medical Society that the resolution had been presented to The Council and to inform that society that the offer of The Council, made on July 11, 1943, would be continued, subject to whatever action the Logan County Medical Society desired to take at some future date.

The Council was also advised of a resolution adopted at a recent meeting of the Health Sub-Committee of the Land-Use Planning Committee reading as follows:

"1. Whereas: The Health Sub-Committee of the Land Use Planning Committee recognize nutrition, sanitation, housing and many other factors as being of equal importance to medical care in rural health.

"2. And Whereas: There is accumulating abundant and convincing evidence that the level of rural health is lower than that of other groups in our country.

"3. And Whereas: There is a growing movement pointing to the development of various types of Federally controlled health insurance plans as a remedy for this condition.

"Now Therefore Be It Resolved: That the Health Sub-Committee of the Land Use Planning Committee hereby states its preference for voluntary health insurance and locally controlled medical plans as opposed to compulsory health insurance and Federally controlled plans, since it believes that the principle of individual initiative should be preserved in our democracy.

"And Be It Further Resolved; That it is our considered opinion that any plan should be developed by local lay groups in cooperation with local professional groups and that when developed it should be under local control. Further, that in the development of any such plan, successive steps should be taken deliberately and after sufficient consideration of needs and desires, bearing in mind that such plans are still in the experimental stage."

On motion by Dr. Schriver, seconded by Dr. Swartz and carried, the Executive Secretary was instructed to advise the Ohio Land-Use Planning Committee that The Council heartily concurs in the sentiments expressed in the foregoing resolution and to express appreciation to Dr. Carll S. Mundy, representative of the Ohio State Medical Association on the Health Sub-Committee of that organization, for the fine work which he is doing.

MISCELLANEOUS

Letters from Better Business Bureaus—A comunication from a representative of the Better Business Bureaus of Ohio, proposing closer cooperation between such bureaus and the Ohio State Medical Association and its component units, was read and discussed at length. Upon motion by Dr. Knoble, seconded by Dr. McNamee and carried, the Executive Secretary was instructed to acknowledge the letter pointing out that the Association has a deep interest in the proposal and expressing the hope that some definite program might be worked out at a later date, but stating that because of curtailed membership it would not be feasible for the Association to enter into any financial agreement with the Better Business Bureau at this time.

Procurement and Assignment Activity—The Executive Secretary reported on activities of the Procurement and Assignment Committee.

Washington Office—There was a general discussion of the activities of the new Council on Medical Service and Public Relations of the American Medical Association. A communication from the Michigan State Medical Society, stating that the Michigan Society intended to continue with efforts to bring about the establishment of an A.M.A. office in Washington, was read and discussed. The members of The Council pointed out that the Ohio State Medical Association, by action of its House of Delegates, already is on record as favoring the establishment of a Wash-

ington office and that it would lend its support to efforts toward implementing this objective.

Obstetrical Program—A communication from the Cleveland Academy of Medicine raising the question of whether medical officers on active duty should or should not be permitted to participate in the Emergency Maternity and Infant Care Program of the U. S. Children's Bureau was read and discussed. On **motion** by Dr. Micklethwaite, seconded by Dr. Noble and **carried** the policy of State Director of Health Markwith in holding that medical officers on active service and any patients cared for by them should not be permitted to participate in the Children's Bureau program was **approved.** It was the feeling of The Council that medical officers should not attempt to provide obstetrical care for wives of enlisted men unless adequate facilities for hospitalization, if needed, are available at the Army or Navy installation where such officers are on active duty and that in no event should medical officers expect to be compensated for services rendered.

Letter on Hospital Policy—A communication from a firm of attorneys representing the Warren City Hospital, referring to the statement of policy on hospital procedures adopted at the last meeting of The Council, was read, discussed and ordered filed.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON
Executive Secretary.

Commission Named to Study Needs of State Institutions

Governor John W. Bricker has named a seven-member committee to study conditions and needs in all state mental institutions. Members are: Dr. George T. Harding, Columbus, Councilor for the Tenth District of the Ohio State Medical Association; Dr. Leonard W. Mayo, dean of the School of Social Sciences, Western Reserve University, Cleveland; Dr. Arthur T. Hopwood, superintenedent of the State Institution for Feeble-Minded, Apple Creek, O.; Probate Judge Charles Chittenden, Toledo; Dr. W. W. Greulich, head of the department of anatomy, Western Reserve University, Cleveland; Hal W. Griswold, Cleveland, attorney and former state welfare director, and Bleecker Marquette, executive secretary of the Public Health Federation, Cincinnati.

According to an announcement from the Governor's office, the committee will be called together soon to elect a chairman and make preliminary plans for its statewide investigation. The committee's function is to observe conditions and needs in the state's feeble-minded institutions and hospitals for the insane and to make recommendations regarding them to the Governor and the State Department of Public Welfare.

Small Supply of Penicillin Available for Civilians; How Needs are Met

Because of numerous requests received by the Army for penicillin, Surgeon General Norman T. Kirk of the Army Medical Department explained in a recent announcement that the War Department "at no time has either controlled penicillin or received the entire output".

The Army's position with regard to penicillin supply is exactly the same as that of the Navy, U. S. Public Health Service, and the Office of Scientific Research and Development, each of which receives a monthly allocation of penicillin from the War Production Board.

General Kirk also explained that the penicillin allocated to the Army Medical Department is intended for the treatment of military personnel and "none of it can be reallocated or released to civilians".

Penicillin is a new drug which prevents the growth of infection bacteria. It is being tried out in Army, Navy and civilian hospitals in the treatment of serious types of infections which will not respond to sulfa drugs. The supply of penicillin is limited and distribution is controlled by WPB.

In November, according to WPB, the Army received 56 per cent of the total supply, the Navy 18 per cent, U. S. Public Health Service (for the treatment of Coast Guard and Merchant Marine personnel) two per cent, the Office of Scientific Research (for civilians) approximately 15 per cent, and the remainder to the scientific staffs of drug companies for their own research.

Though production of the drug is steadily increasing, at present none of the agencies, including the military, receives as much as it needs. Its distributation among military and naval personnel is determined by the Army, Navy, and the U. S. Public Health Service. Distribution of the part allocated to civilians is for clinical research and its assignment is determined by a committee headed by Dr. Chester S. Keefer, Evans Memorial Hospital, Boston. Since the amount of penicillin requested by civilians greatly exceeds the available supply, it has been determined by the Office of Scientific Research and Development that civilian requests must be made through their doctors who should communicate with Dr. Keefer by telephone, telegram or personal letter giving complete details of the case so that he may have an adequate basis for his decision.

Columbus—Dr. C. C. Sherburne, President of the Ohio State Medical Association, told how the passage of the Wagner Bill would affect the public, at a meeting of the Washington C. H. Rotary Club.

"Industrial Health and the Doctor"

Series of Industrial Health Conferences, With Outstanding Guests Speakers, To be Presented February 7, 8, 9, and 10, at Toledo, Cleveland, Columbus, and Cincinnati, Respectively—All members of Association Invited

A SERIES of conferences and programs, carrying out the general theme, "Industrial Health and the Doctor," will be presented the second week in February, 1944, by the Ohio State Medical Association and the Ohio Department of Health at Toledo, Cleveland, Columbus and Cincinnati. All members of the State Association are eligible and urged to attend. Date and place of the four meetings are:

February 7, Toledo, Toledo Academy of Medicine Auditorium;
February 8, Cleveland, Hotel Cleveland;
February 9, Columbus, Deshler-Wallick Hotel;
February 10, Cincinnati, Netherland Plaza Hotel.

A similar program will be presented at each of the four centers. The meetings will begin at 4 P. M., the afternoon session concluding at 6 P. M. and the evening session, starting at 7:45 P.M., concluding at 9:45 P.M. There will be an hour and 45 minutes recess for dinner but no organized dinner will be arranged.

Three out-of-state guests speakers of recognized reputation in the field of industrial medicine and industrial health have accepted invitations of the Committee on Industrial Health of the Ohio State Medical Association and the Ohio Department of Health to address the four conferences. They are:

Carey P. McCord, M. D., Detroit, medical consultant, Chrysler Corporation, and medical director, Industrial Health Conservancy Laboratories, Detroit;

Frank F. Tallman, M. D., Lansing, Mich., director of mental hygiene, Michigan State Hospital Commission;

Rutherford T. Johnstone, M. D., Los Angeles, director, Department of Occupational Diseases, Golden State Hospital, Los Angeles; former professor of medicine, University of Pittsburgh School of Medicine; consultant on occupational diseases, California State Board of Health; author of "Occupational Diseases".

One hour at the afternoon session will be devoted to short informal discussions of the practical aspects of local industrial health problems; the role which the medical society should take, and the responsibilities and obligations, as well as the opportunities, of the individual physician in industrial medicine and industrial health. Selected speakers from local industrial health committees, the Committee on Industrial Health, Ohio State Medical Association, The Council of the State Association, and officials of the Ohio Department of Health and the Ohio Industrial Commission will lead these informal conferences.

The programs for the four meetings are as follows:

FEBRUARY 7, TOLEDO

Academy of Medicine Auditorium

15th at Monroe Street

4:00 P.M.-4:45 P.M.	"Conservation of Industrial Manpower", Carey P. McCord, M.D., Detroit; medical consultant, Chrysler Corporation, and medical director, Industrial Health Conservancy Laboratories, Detroit.
5:00 P.M.-6:00 P.M.	Series of Informal Discussions: 1. "Why A Local Industrial Health Program", (10 minutes). 2. "Planned Activity by the Local Committee on Industrial Health", (10 minutes).

3. "Relationship Between the Medical Profession and the Ohio Industrial Commission", (10 minutes).
4. "The Place of the Individual Physician in Industrial Health", (20 minutes).
5. General Discussion; to be opened by Christopher Leggo, M.D., chief of the Division of Industrial Hygiene, Ohio Department of Health.

6:00 P.M.-7:45 P.M. Recess for dinner.

7:45 P.M.-8:30 P.M. "Absenteeism and the Doctor", Frank F. Tallman, M. D., Lansing, Michigan; director of mental hygiene, Michigan State Hospital Commission.

8:30 P.M.-9:15 P.M. "Occupational Disease Problems and How to Meet Them", Rutherford T. Johnstone, M.D., Los Angeles; director, Department of Occupational Diseases, Golden State Hospital, Los Angeles; former professor of medicine, University of Pittsburgh School of Medicine; consultant on occupational diseases, California State Board of Health; author of "Occupational Diseases".

9:15 P.M.-9:45 P.M. General Discussion.

FEBRUARY 8, CLEVELAND

Hotel Cleveland

4:00 P.M.-4:45 P.M. "Conservation of Industrial Manpower", Carey P. McCord, M.D., Detroit; medical consultant, Chrysler Corporation, and medical director, Industrial Health Conservancy Laboratories, Detroit.

5:00 P.M.-6:00 P.M. Series of Informal Discussions:

1. "Why a Local Industrial Health Program", (10 minutes).
2. "Planned Activity by the Local Committee on Industrial Health", (10 minutes).
3. "Relationship Between the Medical Profession and the Ohio Industrial Commission", (10 minutes).
4. "The Place of the Individual Physician in Industrial Health", (20 minutes).
5. General Discussion; to be opened by Christopher Leggo, M.D., chief of the Division of Industrial Hygiene, Ohio Department of Health.

6:00 P.M.-7:45 P.M. Recess for Dinner.

7:45 P.M.-8:30 P.M. "Absenteeism and the Doctor", Frank F. Tallman, M. D., Lansing, Michigan; director of mental hygiene, Michigan State Hospital Commission.

8:30 P.M.-9:15 P.M. "Occupational Disease Problems and How to Meet Them", Rutherford T. Johnstone, M.D., Los Angeles; director, Department of Occupational Diseases, Golden State Hospital, Los Angeles; former professor of medicine, University of Pittsburgh School of Medicine; consultant on occupational diseases, California State Board of Health; author of "Occupational Diseases".

9:15 P.M.-9:45 P.M. General Discussion.

FEBRUARY 9, COLUMBUS

Deshler-Wallick Hotel

4:00 P.M.-4:45 P.M. "Conservation of Industrial Manpower", Carey P. McCord, M.D., Detroit; medical consultant, Chrysler Corporation, and medical director, Industrial Health Conservancy Laboratories, Detroit.

5:00 P.M.-6:00 P.M. Series of Informal Discussions:

1. "Why a Local Industrial Health Program", (10 minutes).
2. "Planned Activity by the Local Committee on Industrial Health", (10 minutes).
3. "Relationship Between the Medical Profession and the Ohio Industrial Commission", (10 minutes).
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9:15 P.M.-9:45 P.M. General Discussion.

FEBRUARY 10, CINCINNATI

Netherland Plaza Hotel

4:00 P.M.-4:45 P.M. "Conservation of Industrial Manpower", Carey P. McCord, M.D., Detroit; medical consultant, Chrysler Corporation, and medical director, Industrial Health Conservancy Laboratories, Detroit.

5:00 P.M.-6:00 P.M. Series of Informal Discussions:

1. "Why a Local Industrial Health Program", (10 minutes).
2. "Planned Activity by the Local Committee on Industrial Health", (10 minutes).
3. "Relationship Between the Medical Profession and the Ohio Industrial Commission", (10 minutes).
4. "The Place of the Individual Physician in Industrial Health", (20 minutes).
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9:15 P.M.-9:45 P.M. General Discussion.

Induction of Available Physicians to Meet Special Needs of Armed Forces Indicated in Revised Federal Act

ALL three branches of the armed forces are in immediate dire need of several thousand additional medical personnel, the Directing Board, Procurement and Assignment Service for Physicians, War Manpower Commission stated in a recent directive to all state chairmen.

The Ohio Procurement and Assignment Committee is continuing with its re-appraisals of physicians of military age, including those who had been rejected for physical reasons but whom the surgeons general of the Army and Navy feel may be able to meet the modified physical standards now in effect.

In compliance with the Directing Board's instructions, the names of Ohio physicians who are classified as available but who do not apply for a commission have been, and will continue to be, certified to the State Director of Selective Service for any action which Selective Service can take under the law and regulations toward re-classification and possible induction.

NEW LEGAL PROVISION

According to officials of Ohio Selective Service Headquarters, revisions made in the Selective Service Act through the enactment of S. 763 and approved on December 10, provide one important change in the Selective Service status of physicians.

The recently-enacted law sets forth different procedures for the classification and induction of registrants, including the following provision:

"Provided, That no individuals shall be called for induction, ordered to report to induction stations, or be inducted because of their occupations, or by occupational groups, or by groups in any plant or institutions, **except pursuant to a requisition by the land or naval forces for persons in needed medical professional and specialist categories.**"

UNOFFICIAL INTERPRETATION

No regulations have been issued as yet by National Selective Service Headquarters, interpreting the above provision, but unofficially it has been interpreted to mean that special quotas for physicians could be established and physicians who are classified as available for military service could be inducted under special procedures, regardless of order number, in event the Army or Navy would make special requisition for medical officers.

Unless the present voluntary recruiting program for medical officers produces more satisfactory results in the immediate future, there is a possibility that induction of a sufficient number of physicians to meet existing needs of the armed forces will be initiated under that section of the revised Selective Service Act.

At present State Selective Service Headquarters has appeals pending on a number of physicians who are classified as available and whose local boards have not ordered them for induction. Under the law and regulations the State Director of Selective Service may appeal the classification of a physician—exercising the same right granted to the registrant. If the appeal is won by the director, the physician involved will be inducted, unless he carries his appeal to the President and is sustained.

QUESTIONS AND ANSWERS

Following are a list of questions, with the answers, which are frequently asked by physicians, prepared by the Washington office of the Procurement and Assignment Service and submitted to *The Journal* for publication:

Q. What are the present age limits for services in the Medical Corps of the Armed Forces?

A. The upper limit in the Army is, in general, the 45th birthday, but for specific position vacancies men up to 60 are eligible. The limit in the Navy is, in general, the 50th birthday.

Q. What is the present status of physical requirements?

A. The Navy at the present time still has the highest standards, although they are lower than they were. The Army is next, and those who are physically disqualified for Army service may be eligible for commission in the United States Public Health Service.

Q. What ranks are being offered by the services at the present time?

A. The Army is limiting those under 38 to first lieutenancies and those about 38 and over, to captaincies and above if they meet special requirements of the Surgeon General. The latter rank depends upon special qualifications. The Navy is limiting those 34 and under to lieutenancies, jr. gr., those from 34 to 38 lieutenancies, sr. gr., and those from 38 to 44 lieutenant commanderships. For specific position vacancies requiring special qualifications higher commissions may be offered. The Public Health Service has commissioned ranks similar to those in the Army.

Q. What are the present needs of the services?

A. All three branches of the Armed Forces are in immediate dire need of several thousand additional medical personnel.

Q. Why is the Public Health Service classed as one of the branches of the Armed Forces as far as medical officers are concerned?

A. For many reasons, among them the fact that they supply the medical personnel for the U.S. Coast Guard. Physically qualified eligible officers are assigned by the Public Health Service for active duty with the Coast Guard and may be assigned anywhere the American flag flies.

Q. Why have so many practitioners who are capable of serving long hours in civilian practice been disqualified for military service?

A. The exigencies of service in combat areas are such that civilian practice is no criterion of physical qualification. The services at the present time have a full quota of those that they can accept for limited duty. They are being forced to discharge some at present. Certain individual physicians who still will be able to undertake heavy civilian duties are no longer able to cope with the needs of combat troops.

Q. Why is it necessary for a physician to take an indoctrination course after entering the Medical Corps?

A. The reason for this is that a physician becomes a medical officer, which means that he is at all times an officer subject to the duties of other officers of other branches of the service. He must be responsible for those under his command and must be entirely capable of meeting any situation which confronts such personnel as is under his direct supervision whether it be in open field duty requiring the setting up of field hospitals or the maintenance of food supply and shelter for his personnel, as well as a correlation of the activities of his group with the other services under the same command.

Q. Is it true that the Armed Forces are not making efficient use of their medical personnel?

A. There have been many occasions in the past when appearances would lead anyone to believe that they were not. At the present time efficient use is being made of such personnel, and it must always be remembered in this connection that a reserve supply of such personnel must be maintained for immediate assignment to duty. Such a group must have been trained together to meet the situations it will face immediately after assignment and cannot be gathered together at the last minute to be assigned to some specific post. Furthermore, the planning of any military campaign requires a complete line-up of all services. If reverses are suffered such men who are held in preparation of projected positions may not be able to fill such positions and must be held for further plans. War, by its very nature, is not essentially efficient, but the lack of medical personnel in the various branches of the Armed Forces has resulted in a high increase in their efficient use.

Q. On the basis of present ratios of physicians to individuals, which service has the greatest need at the present time?

A. The Army ratio is slightly over 5 per 1,000, whereas the Navy is somewhat under 4 per 1,000. Therefore, the Navy needs men somewhat more than the Army.

Q. Why is any man under 38 ever classified as essential?

A. He is only essential if he were to leave his community or his institution and there were no replacement for him. No man under 38 is, as a general rule, considered permanently essential, but only essential until he can be replaced by another physician who is not eligible for service with the Armed Forces.

Q. Has not the civilian population been endangered by the number of physicians who have entered the Armed Forces?

A. Not for the Nation at large. There are various problems of redistribution which have been partially or completely solved and some which will be difficult to solve, but if such distribution is equitable there is no shortage at present for minimal adequate civilian care.

Q. Will not the needs of the services continue and require that additional personnel leave civilian life?

A. To some extent, yes, but eventually the services hope to meet their own needs for replacement from the students they are training at present. The Navy may need some additional personnel even though they are also training students. The Public Health Service will continue to have needs since they do not have any students in training.

Q. Why do not the Armed Forces adopt the liberalization of qualifications that exist in England and elsewhere?

A. Because it is essential that American standards be maintained for the men in the Armed Forces as well as on the home front. Comparisons with the Armed Forces of other Nations are not in order any more than comparisons of physician-population ratios on the home front are with those of other Nations. The mortality in the Armed Forces at the present time is astoundingly low and every effort will be made to keep them at that level. This will obviously require further sacrifices on the part of those on the home front, but the Procurement and Assignment Service is constantly aware of the fact that supplies of all kinds must continue to flow to those who are on active duty and that therefore the health of the home front is as much a part of the war effort as is the health of the soldier.

Names of 19 Ohio Physicians Added to Military Roster; 2,683 Grand Total of Those in Various Services Now

THE names of 19 Ohio physicians were added to the roster of medical officers serving in the Army, Navy or other Federal services since November 23. The total number of Ohio medical officers on active duty as of December 21, 1943, was, Army, 2,296; Navy, 324; o'her service, 63; total 2,683. During the month 14 Ohio physicians were separated from the services. Those whose names were placed on the roster during the past month, those promoted, and the tabulation by counties, follow:

NAMES ADDED TO MILITARY ROSTER

Name	City	Rank
Ackerman, Garrett B.	Columbus	1st. Lt. U.S.A.
Bucher, L. F.	Dayton	1st. Lt. U.S.A.
Campbell, Howard R.	Dayton	1st Lt. U.S.A.
Canowitz, Aaron S.	Columbus	1st. Lt. U.S.A.
Eliott, Philip H.	Zanesville	Lt. Comdr. U.S.N.
Grimm, Paul E.	Columbus	Lt.. (j. g.) U.S.N.
Gusman, Harry A.	Cleveland	Lt. Comdr. U.S.N.
Huggins, Kenneth E.	Cincinnati	1st Lt. U.S.A.
Joseph, James W.	Cincinnati	Lt. U.S.N.
Kent, Louis R..	Youngstown	Major U.S.A.
Kuby, Wm.	Cincinnati	Capt. U.S.A.
Lyon, Robert C.	Cincinnati	Major, USP.H.S.
Noble, Keith C.	Cleveland	1st. Lt. U.S.A.
Scanlon, Charles F.	Cincinnati	Capt. U.S.A.
Schlueter, Franklin C.	Cincinnati	1st Lt. U.S.A.
Srigley, Robert S.	Columbus	1st Lt. U.S.A.
Tatum, C. F.	Akron	1st.. Lt. U.S.A.
Van Buren, Harlow K.	Carey	Capt. U.S.A.
Wright, Joseph F.	Cincinnati	1st.. Lt. U.S.A.

WIN PROMOTIONS

Name	City	Rank
Black, Albert V.	Dayton	Capt. U.S.A.
Bowsher, Robert E.	Toledo	Major U.S.A.
Burgner, E. W.	Akron	Major U.S.A.
Carson, J. H.	Martins Ferry	Lt. Col. U.S.A.
Cohen, Sander	Cincinnati	Major U.S.A.
Deger, Robert J.	Dayton	Capt. U.S.A.
Diggs, Arthur O.	Mansfield	Major U.S.A.
Dugan, David J.	Lakewood	Capt. U.S.A.
Evans, Geo. L.	Mansfield	Capt. U.S.A.
Felson, Walter	Greenfield	Capt. U.S.A.
Firestone, B. I.	Youngstown	Capt. U.S.A.
Franz, Lyle C.	Ripley	Capt. U.S.A.
Goodman, Milton L.	Columbus	Capt. U.S.A.
Greenburg, S. L.	Steubenville	Major U.S.A.
Haas, Richard L.	Dayton	Capt. U.S.A.
Hallaran, Wm. R.	Cleveland	Lt. Col. U.S.A.
Hardgrove, Geo. L.	Doylestown	Major U.S.A.
Harrold, Arvine W.	Tiffin	Capt. U.S.A.
Haubrich, Roberts	Pataskala	Capt. U.S.A.
Hauser, J. W.	Cincinnati	Capt. U.S.A.
Hedges, Jasper M.	Columbus	Capt. U.S.A.
Hayes, Thomas M.	Springfield	Capt. U.S.A.
High, Luther W.	Millersburg	Capt. U.S.A.
Hunter, Howard M.	Hamilton	Major U.S.A.
Hyde, B. E. L.	Troy	Lt. Col. U.S.A.
Jacobs, R. B.	Dayton	Capt. U.S.A.
Janney, J. R.	North Baltimore	Capt. U.S.A.
Jansen, Jos. H., Jr.	Cincinnati	Capt. U.S.A.
Kessler, Ralph J.	Cincinnati	Capt. U.S.A.
Kirk, Robert C.	Columbus	Major U.S.A.
Kirk, T. M.	Dayton	Lt. Col. U.S.A.
Kriendler, Louis	Cincinnati	Capt. U.S.A.
Lazarus, Lawrence	Cleveland	Capt. U.S.A.
Leonard, D. E.	Cuyahoga Falls	Capt. U.S.A.
Marshall, Merritt K.	Findlay	Capt. U.S.A.
Martin, John E.	Columbus	Capt. U.S.A.
Masters, W. Eugene	Columbus	Comdr. U.S.N.
McCormick, J. E.	Zanesville	Major U.S.A.
McGavran, Chas. W.	Columbus	Capt. U.S.A.
McGraw, Elmer	Toronto	Capt. U.S.A.
McLin, Wm. M.	Dayton	Capt. U.S.A.
Moore, F. T.	Cuyahoga Falls	Lt. Col U.S.A.
Mowery, John H.	Conneaut	Capt. U.S.A.
Musser, H. O.	Akron	Lt. U.S.N.
Ockington, James W.	Lakewood	Major U.S.A.
Pickard, Edgar C.	Stow	Major, U.S.A.
Price, Frederick F.	Stony Ridge	Capt. U.S.A.
Pritchett, Clark	Columbus	Major U.S.A.
Quinn, Gerald Wm.	Akron	Capt. U.S.A.
Randell, Asher	Youngstown	Capt. U.S.A.
Robert, W. C.	Akron	Major U.S.A.
Rodabaugh, Galon S.	Basil	Capt. U.S.A.
Rosenblum, Earl	Steubenville	Lt. Col. U.S.A.
Ryan, W. J.	Akron	Capt. U.S.A.
Sachs, E. W.	Dayton	Capt. U.S.A.
Sagebiel, Jas. L.	Dayton	Comdr. U.S.N.
Schulze, Alfred G.	Amelia	Capt. U.S.A.
Sheinin, Louis	Akron	Capt. U.S.A.
Shulman, Leon	Steubenville	Capt. U.S.A.
Snyder, Robert D.	Dayton	Major U.S.A.
Somma, Fred F.	Dayton	Capt. U.S.A.
Tingwald, Fred L. R.	Youngstown	Capt. U.S.A.
Troup, Paul	Dayton	Major U.S.A.
Werner, M. R.	Akron	Capt. U.S.A.
Williams, J. A.	Cincinnati	Capt. U.S.A.
Yingling, N. E.	Lima	Major U.S.A.

TABULATION BY COUNTIES

Adams	2	Guernsey	6	Muskingum	9
Allen	38	Hamilton	398	Noble	1
Ashland	10	Hancock	13	Ottawa	9
Ashtabula	17	Hardin	7	Paulding	2
Athens	12	Harrison	4	Perry	4
Auglaize	6	Henry	2	Pickaway	5
Belmont	12	Highland	8	Pike	2
Brown	4	Hocking	4	Portage	2
Butler	28	Holmes	2	Preble	7
Carroll	1	Huron	14	Putnam	6
Champaign	8	Jackson	1	Richland	38
Clark	31	Jefferson	31	Ross	24
Clermont	9	Knox	11	Sandusky	11
Clinton	7	Lake	18	Scioto	19
Columbiana	11	Lawrence	7	Seneca	12
Coshocton	4	Licking	17	Shelby	7
Crawford	9	Logan	8	Stark	97
Cuyahoga	652	Lorain	36	Summit	148
Darke	6	Lucas	151	Trumbull	28
Defiance	4	Madison	6	Tuscarawas	19
Delaware	6	Mahoning	108	Union	2
Erie	9	Marion	14	Van Wert	9
Fairfield	9	Medina	13	Vinton	2
Fayette	2	Meigs	3	Warren	4
Franklin	218	Mercer	6	Washington	7
Fulton	6	Miami	13	Wayne	13
Gallia	5	Monroe	1	Williams	8
Geauga	4	Montgomery	131	Wood	17
Greene	7	Morgan	3	Wyandot	3
Total					2,683

Tags for Diabetics Available

At the suggestion of the medical division of the U. S. Office of Civilian Defense, to prevent dangerous delay in diagnosis and proper treatment during unconsciousness or coma, Eli Lilly Company, Indianapolis 6, in cooperation with American Diabetes Association will provide metallic identification tags to be worn by diabetic patients or carried in the pocket, carrying the inscription "If Ill DIABETIC Call Physician." No advertisment of any sort appears on the tags which will be supplied to the medical profession on request.

Medina—A campaign is under way to raise $25,000 for the Community Hospital.

Purposes and Plans of the New Council on Medical Service and Public Relations of A.M.A. Outlined in Statement

PURPOSES and functioning of the Council on Medical Service and Public Relations of the American Medical Association, created at the 1943 session of the House of Delegates of the A.M.A., were reviewed and analyzed in a recent statement issued by the Council for the information of all members of the American Medical Association.

Members of the Council are: Dr. Louis H. Bauer, Hempstead, N.Y., chairman; Dr. James E. Paullin, Atlanta, president of the A.M.A.; Brig. Gen. Fred W. Rankin, Lexington, Ky., past president of the A.M.A.; Dr. Roger I. Lee, Boston, chairman, Board of Trustees of the A.M.A.; Dr. Olin West, Chicago, secretary, A.M.A.; Dr. Alfred W. Adson, Rochester, Minn.; Dr. John H. Fitzgibbon, Portland, Ore.; Dr. W. S. Leathers, Nashville; Dr. Edward J. McCormick, Toledo; and Dr. James R. McVay, Kansas City, Mo.

SECRETARY SELECTED

At its last meeting the Council selected Dr. G. Lombard Kelly, dean of the University of Georgia School of Medicine, as secretary. He will assume office on January 1 and it is anticipated that he will devote much of his time to field work for the Council and among the various states.

Following is the text of the statement released by the Council describing its contemplated activities:

TEXT OF STATEMENT

The Council was authorized by the House of Delegates of the American Medical Association at its annual session in Chicago in June, 1943. The members of the Council were immediately appointed by the Board of Trustees. Section 4 of Chapter IX of the By-Laws provides that the duties of the Council shall be as follows:

"(1) To make available facts, data and medical opinions with respect to timely and adequate rendition of medical care to the American people;

"(2) to inform the constituent associations and component societies of proposed changes affecting medical care in the nation;

"(3) to inform constituent associations and component societies regarding the activities of the Council;

"(4) to investigate matters pertaining to the economic, social, and similar aspects of medical care for all the people;

"(5) to study and suggest means for the distribution of medical services to the public consistent with the principles adopted by the House of Delegates, and

"(6) to develop and assist committees on medical service and public relations originating within the constituent associations and component societies of the American Medical Association.

"In the exercise of its functions, this Council, with the cooperation of the Board of Trustees, shall utilize the functions and personnel of the Bureau of Legal Medicine and Legislation, the Bureau of Medical Economics and the Department of Public Relations in the Headquarters Office."

The Council is also bound by the actions of the House of Delegates on the subject of medical care and its distribution, notably the platform adopted in 1937 as amended and amplified in subsequent years by the various resolutions and reference committee reports adopted by the House of Delegates.

In order to carry out these functions, the Council has organized as follows:

ORGANIZATION

Officers—The Council shall elect annually:

A chairman.
A vice-chairman.
A full-time secretary.

An executive committee of three shall be created, which shall include the Chairman, the Council member of the Board of Trustees, and a third member to be chosen annually from the duly appointed or elected members of the Council on Medical Service and Public Relations. This committee shall exercise such functions as are delegated to it by the Council.

The central office of the Council is to be located in the office building of the American Medical Association in Chicago, Illinois.

The functions of the Council outlined in the By-Laws are closely integrated and cannot well be considered separately. To carry them out it is obvious that the Council must have adequate sources of information, maintain close contact with constituent associations and component societies, and establish close relationship with the already existing Bureaus and Departments of the Association.

METHODS OF OPERATION

The Council, therefore, subject to the approval of the Board of Trustees, has decided on the following methods of operation:

1. In carrying out the directives in the By-Laws as to relationship with the other Bureaus and Departments of the Association, the Council has established close collaboration (a) with the Bureau of Medical Economics, which has been asked and has expressed the willingness to do the research on many of the economic problems necessary for the Council's study, and which is well equipped to carry out such research; (b) with the Bureau of Legal Medicine and Legislation. Joint bulletins will be issued with that Bureau on legislative matters. Attempt will be made to effect wider distribution and, if necessary, more frequent publication of such bulletins; (c) with the Department of Public Relations. The Council shall utilize the sources of information of this department and joint bulletins may be issued from time to time with it, and if indicated with other bureaus of the American Medical Association. All planning will be to avoid overlapping of functions and duplication of effort.

2. The Council on Medical Service and Public Relations has extended the sources of information of the American Medical Association on problems with which the Council is specifically con-

cerned. Through its membership and by cooperation with constituent associations and component societies and the utilization of other facilities, the Council will disseminate such information toward effecting its objectives. The Secretary of the Council, with its approval, will undertake such travel as may be necessary.

STATES ASKED TO HELP

3. In order that constituent associations and component societies may be kept informed of the activities of the Council, and of proposed changes in the status of medical care, and that the Council may be of assistance to those associations and societies, the Council has requested each State Association to designate an existing committee or create a new committee to function with the Council on a State level.

Each State organization has also been requested to contact each component society in the State and ask it similarly to designate or form a committtee to function in connection with the programs of the Council. Where such organization is feasible, it has been suggested that committees be created along the lines of congressional districts.

Such State and county committees have been urged to keep the Council informed of their local problems and activities.

State organizations also will be requested from time to time to conduct experiments in the various methods of medical care and to inform the Council of their results so that the Council may study and evaluate the experiments and transmit the information acquired to all concerned.

4. The Council feels that under its directive it is its duty to endeavor to evolve such modifications of our present system of medical care as may be necessary to cover all the people and be in accord with the traditions of American Medicine as to high standards of medical care and the American tradition of free enterprise as already outlined in paragraph 1 of the Council's Policies previously published. To accomplish this, study must be made of all economic, social, and similar aspects of such care.

TO INFORM MEMBERS

5. In order that the above program may be effectively carried out, the Secretary of the Council, with the guidance of the Council in conformity with the above expressed relationships with other Bureaus and Departments, shall inform the profession through the various State organizations of all pending national legislation and bureau directives affecting the practice of medicine. It shall likewise be his duty with the guidance of the Council, to arrange for medical representation at meetings and hearings pertaining to medical care, collaborating in the representation with other Councils and Bureaus of the American Medical Association who have an interest in this same subject.

6. The Secretary is instructed with the supervision of the Council, and in collaboration with the Department of Public Relations, to disseminate information concerning the activities of the Council through the publications of the American Medical Association and the various state and medical journals, and to prepare and release information on medical care.

The Council has already issued its Statement of General Policies, and it will act in accordance with those Policies and the above methods of functioning.

MORE WAGNER BILL PAMPHLETS AVAILABLE; GET A SUPPLY NOW

Requests for the pamphlet, "No! The Wagner Bill Is Not The Answer", have necessitated the printing of 150,000 additional copies. That's 300,000 to date! **Your county society secretary has a supply.** If he needs more, he can get them from the State Headquarters Office. He also has a "model" address on the Wagner Bill which you can use in addressing a luncheon club or other local organization; also a news release for the newspapers when such a talk is made. **This material is all yours for the asking.** It will be effective in proportion to the extent that it is utilized by individual physicians.

Sixth Annual Forum on Allergy in St. Louis, January 22-23

The Sixth Annual Forum on Allergy will be held at the Hotel Statler, St. Louis, Saturday and Sunday, January 22-23. All physicians who are interested in bringing themselves up-to-date in this rapidly advancing branch of medicine, by two days of intensive postgraduate instruction, are invited to attend. There will be 15 study groups begining at 9 o'clock Saturday morning, any three of which will be open to a registrant. The meeting continues with lectures beginning at 1:30 P. M. Saturday, additional sessions Saturday evening, Sunday morning and Sunday afternoon. Speakers include many of the outstanding allergists in the country. Ohioans participating in the program are:Dr. George Rockwell, Cincinnati; Dr. Karl D. Figley, Toledo; Dr. Milton B. Cohen and Dr. W. P. Garver, Cleveland, and Dr. Karl D. Way, Akron. The program has been arranged and directed by Dr. Jonathan Forman, Columbus. Details concerning the meeting and a copy of the program can be obtained by addressing him at 394 E. Town St., Columbus.

Payroll Tax Frozen Again

Postponement of a scheduled 100 per cent increase in the Social Security payroll tax was voted by the Congress on December 17. Under the present law the tax was slated to increase January 1 from one per cent each on employers and employees to two per cent each. If approved by the President, the tax will be frozen at one per cent until March 1, 1944.

Columbus—Dr. Donald F. Bowers, recently installed as president of the Buckeye Republican Club, spoke on "Wartime Medicine" at a meeting of Exchange Club.

"America Must Not Be Shackled", Medical Society Warned In Address Made by Congressman Martin, Massachusetts

ON October 1, 1943, the Fifteenth Annual Scientific Assembly of the Medical Society of the District of Columbia was addressed by Congressman Joseph W. Martin, Jr., of the State of Massachusetts. His subject was "America Must Not Be Shackled".

As Mr. Martin is Republican leader of the House of Representatives he obviously made some statements which would be interpreted as expressing a partisan point of view. *The Ohio State Medical Journal* is not interested in those phases of his address, but it is interested in those observations which he made as an able statesman and staunch American concerning current trends and developments vitally affecting the health of the American people and the medical profession. Many of his comments and warnings should be heeded by those citizens who are interested in preserving private enterprise, eliminating the shackles of bureaucracy and regimentation, and maintaining the high standards of health services.

MUST AVOID DICTATORSHIP

After leading off with a tribute to the medical profession for its accomplishments and enumerating many of them, Mr. Martin said:

"This you have been able to accomplish because your profession has been free. It has been free to dare. It has been free to progress. You have had the assurance of great personal satisfaction in rendering indispensable services to your fellow men. You could expect some measure of material reward for your investment in years of education and hard study and devotion to your profession.

"Under the harsh necessity of war, your law-making body, the Congress, has delegated enormous powers to the several branches of the executive department of this Government. There was no escape from this procedure. The details of war activity must be administered by the executive machinery. But having yielded these powers, the Congress has a covenant with the people of America carefully to watch the exercise of these vast powers and be ready to curb and correct any abuses. Congress must be ready to amend, restrict or even recall any authority it has granted if new conditions, or the abuse of power make it essential to the public interest to do so. Above all, it is the solemn responsibility of Congress, if we are to keep faith with the people, to revoke these enormous powers when the war is over. It would be a futile victory if we were to win a war over dictatorship abroad only to have a permanent dictatorship fastened upon America at home".

WARNS MEDICAL PROFESSION

Referring to certain groups whose chief aim is to foist some brand of state socialism onto the American people, Congressman Martin, although he did not mention specifically the Wagner-Murray-Dingell Bill, warned the medical profession of what is in store if such groups have their way:

CLIP AND SAVE

Clip and save this article for your Wagner Bill File. You will find it handy for future reference.

"I do not need to remind you," he said, "that one of these groups would radically change the status of your profession. Instead of leaving you free, they would regiment you under a rigid system of governmental controls. They would curb your opportunities. They would arrest your progress. They would deprive you of your freedom. And they would do all this under the specious plea of aiding the unfortunate and giving all people security.

"These misguided individuals evidently forget that if you regiment men and women, if you eliminate the opportunity for individual progress, you kill individual initiative at the same time.

"A ward of the state, with specific limitations and a fixed income, operating under the direction of a bureaucrat who may himself possess no scientific knowledge, would not, except in rare instances, put in the long hours of intensive study and experimentation necessary to blaze the way for progress. A physician on a fixed salary and in a treadmill practice would not have the same urge to watch zealously over those in his care as the physician whose patient is his personal, individual responsibility. By destroying initiative and progress, we might well be sentencing vast numbers of people to earlier death because we could not as intelligently cope with disease.

MUST MEET NEEDS RIGHT WAY

"Every one of us has a definite interest in seeing that every child, every woman and every man secures adequate medical aid and care. We can and we will, as a government, discharge our full obligations to the sick, the aged, and the unfortunate, unable to pay their own way. But we must do it in the American way—in a way which will preserve the spirit and the initiative of the men and women of your profession. They must be encouraged to go ahead with studies and experiments; to make new and greater scientific discoveries for the benefit of mankind. And we must care for our ailing ones in such a way that every patient will not be a ward and pawn of an all-powerful state.

"We must not shackle your great profession and restrict the service it can give to the world. If we give to some bureaucrat the power to regulate the practice and fix the fees of a physician and to govern the hospitals, we will shackle the science of medicine. We must make sure every man and every woman retains the right

to select the doctor of his or her own choice. That has been a great American right and the people of this country want to keep it.

WOULD AFFECT ALL GROUPS

"To place the practice of medicine under bureaucratic control would not affect medicine alone; it would constitute a long forward step in putting the other professions and all American labor, industry, and agriculture permanently under the direction of a Washington bureaucracy. By whatever name we might call it, it would be a form of state socialism.

"You plainly see the threat hovering over your own profession, and you are not alone in your anxiety. Other classes in our national life face a similar peril.

"All professions and all business, big and small alike, face the menace of a new era in which private enterprise will no longer have a free opportunity to flourish.

"Only through an aroused people, determined to preserve our free way of life and the private enterprise system which has given so much to every American, regardless of race, color, religion, or social status, can we save our heritage."

AMERICAN SYSTEM THE BEST

Reviewing in some detail the accomplishments which have been made by America under its system of free enterprise and pleading for action on the part of citizens which will permit business and the professions that freedom which is so necessary for additional progress, the Massachusetts Congressman declared:

"Let us constantly remind ourselves that while it may have faults, the American system has provided its people with more happiness and more of the comforts of life than have ever been enjoyed by the people of any other land.

* * *

"We must defeat any efforts to curb private enterprise and to put all business and the professions under the domination and direction of an all-powerful bureaucracy. To fail to preserve our American way will mean we shall have lost the war, regardless of how complete may be our victories over our enemies abroad.

* * *

"Sensing this danger, those of us who believe in a free and strong America, must be on guard to prevent any misuse of the power which has been achieved over industry in the war effort.

"Put the farmer, industry, and the professions in a strait jacket of regimentation and bureaucratic control, and the only possible result would be we should lose the way of life which has given the people of this Nation more of the worth-while things than have been attained by the people of any other land.

DARE NOT SIT IDLY BY

"What are we to do about it? We cannot sit idly by and watch this system disappear before our eyes. We cannot permit the inefficient and the incompetent, the crystal gazers and the experimenters, to ruin this America of opportunity for all of us.

"The people look for protection to their Congress. I believe they have, in their lawmaking body, a confidence that has been vastly increased of late because the rubber stamp has been scrapped. Congress must not betray that confidence. We must not, as direct spokesmen for a great people, permit bureaucrats, lustful for power and possessing no direct responsibility to the people, to overstep their constitutional authority and, through administrative regulations and directives, write the laws of this land.

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SAYS CONGRESS IS AWAKE

"I believe Congress will accept the great American challenge of our generation. We shall not permit the bureaucrats, as someone has said, to be the 'masters of the people from the cradle to the grave.'

"I do not believe the people, or their Representatives in Congress, will permit business, agriculture, and the professions to be permanently controlled by the bureaucrats through regimentation.

"We can and we must preserve the full freedom of private endeavor. We can and we will give aid to the socially handicapped without destroying the rights of the States and their responsibilities, and without building up an ever-expanding Federal domain. We must provide adequately for the aged and the unemployed.

"We can meet these demands and at the same time retain our American framework of Government. Let us insist it be done this way.

ACCOMPLISHMENTS OF FREE AMERICA

"Let us look briefly at some of the accomplishments of a free America. Here the airplane was born. The sewing machine had its development in this country. The steamboat was developed here. The railroad was brought to its highest state of efficiency. The contribution of one American, Thomas A. Edison, to the progress of humanity was the phonograph, the incandescent lamp, the motion picture camera. Alexander Graham Bell gave the world the telephone, while Morse perfected the telegraph. The automobile reached its flower under the free enterprise system of America.

"No one can possibly deny that it is in the fertile soil of free government, with the benign impulse of free enterprise to fertilize it, and with a free society ever ready to reap and use, that the greatest contributions in the last 150 years have been made to the spiritual, the cultural, and the material progress of the whole race.

"Is is not incredible that any sane man or woman should want to change a system which could produce so much in less than a century and a half for the progress of mankind? We can improve our American way, but there is no adequate substitute for it.

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"Let us prepare now to make certain that the policy which we follow at the end of this war shall be an American policy, one which has been demonstrated through years of fruitful experience to have brought the best results.

"The vast majority of our people are essentially sound thinking. I feel sure I know what their decision will be."

In Our Opinion:

Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

Two years ago "In Our Opinion" was laid on the shelf—a victim of the war. The war isn't over by a long shot but those war demands which made it necessary to put this department in moth balls have tapered off to such an extent that some time and effort can be devoted now to production of comment on current economic, social and legislative happenings and trends of interest to Ohio physicians.

Out of the Moth Balls After Two Long Years

We hope to produce an "In Our Opinion" each month. We will try to make it snappy and meaningful. We won't attempt to settle each and every question. Our effort will be directed toward giving readers of *The Journal* something to think about—something which will stimulate action.

Readers of *The Journal* may find reason to disagree with our views from time to time. It will be only natural if honest differences of opinion arise. Those who disagree with what we say and how we say it should feel free to give us their views and opinions. This will not be a "letters to the editor" column but if anyone has something good to offer, we will give it a whirl. This applies to those in the services as well as to those on the home front.

Elsewhere in this issue will be found a statement issued by the new Council on Medical Service and Public Relations of the American Medical Association, analyzing the purposes and functions of the new body.

Some Suggestions From the Grass Roots Might Be Helpful

The principles announced by the council are sound. It has laid out an excellent agenda. In our opinion, the council is composed of high-class physicians, possessing plenty of talent and the desire to do a real job.

In some parts there has arisen a defeatist attitude concerning the possibilities and accomplishments of this newly-created and badly-needed agency. We are not ready to take that attitude—at least we are ready to give the council ample opportunity to show whether or not it has something on the ball.

If we may be presumptuous enough to offer a suggestion, we recommend to the new council that as one of its first jobs it engage in some good old-fashioned field work, or have its new secretary and his associates do so. In other words, the council ought to find out what is going on in the grass roots; what the physicians in all nooks and corners are thinking about; how they would like to see their national association handle its public relations.

True enough, the House of Delegates of the A.M.A. sets the policies but the new council could play a big part in convincing the House of Delegates that perhaps some of its policies should be revised, so as to permit a little more zip in public relations if the council had substantial evidence from the grass roots indicating that a change would be welcomed by the rank and file.

For example the council, as well as the House of Delegates, might be surprised if they knew how a substantial number of the members-in-the-rear-rank, but members, nevertheless, line up on the issue as to whether the medical profession should or should not have a full-time office in Washington, D.C. That question is still an issue—not a dead duck as some believe.

Ohio doctors are ready and willing to give the Council on Medical Service and Public Relations their active support and cooperation. They do not expect it to perform miracles. They do not expect it to start off in high gear but they are expecting it to get into gear without too much delay and to keep moving in the right direction once it gets started. Since it can't play a lone hand it needs, and deserves, the help of those in both high and low places within medical organization.

In the near future, the Committee on Education of the Ohio State Medical Association will meet for the purpose of laying the basis for a study of the needs and facilities pertaining to post-graduate education for Ohio physicians when separated from the armed forces, before or after the end of hostilities.

Postwar Educational Program To Be Considered by Committee

The importance of this question cannot be exaggerated. It is perfectly obvious that medical organization can and must take a leading part in devising methods and programs which will provide facilities and opportunities for re-

fresher work courses for returning medical officers.

This is a job also for medical schools and hospitals. Representatives of those groups will be requested to join the Committee on Education in its deliberations.

The committee will be starting at scratch. It will need advice and suggestions. Therefore, it will welcome ideas and help from medical veterans of the First World War based on their experiences at the close of that war, as well as recommendations from the medical officers who are carrying the torch in World War No. 2.

What suggestions have you for consideration of the committee?

Showdown on Dictatorships By Bureau Approaching

We'll wager even money right now that it won't be long until the masters of strategy within the U.S. Children's Bureau will come forth with a recommendation (that is what they call it but some like to term it "directive") that the states revise their present programs of emergency maternity and infant care for the wives and children of service men to include general medical and surgical care for service men's wives—at least partial coverage. And, we'll lay another bet that there will be no provision to handle this on a cash allotment basis.

That's another step toward Federalized medicine, you say! Of course. Just a few more steps and Senator Wagner can junk his bill. It won't be needed by him to accomplish his purpose as others will have done the job for him.

The wife of any service man who needs medical or surgical care deserves the best professional services available. If she cannot afford such care, it is the obligation of the government or some responsible private agency to provide the funds. These points are taken for granted.

But, how long are Congress and the people going to let the Children's Bureau act as the supreme dictator on such matters? If we are going to have a general Federal medical program, is Congress going to say what it shall be, or is the present policy of permitting a bureau of political appointees to draw the blueprint and administer it going to be continued indefinitely? Is the medical profession of this country going to have an opportunity to offer suggestions and to criticize, or is it going to have more and more programs shoved down its throat, and told to like them or lump 'em? How long is "for the duration"? How soon are we going to get back to applying the yardstick of need to decide who shall or shall not be entitled to public funds or the services provided at public expense? If a Federalized medical program is needed for the wives of service men, will one be needed for the service men themselves when suffering from non-service connected disabilities? Is some bureau going to decide that and write the ticket, or will Congress be the judge and author of the plan?

Looks as if there might be troublesome times ahead, doesn't it? How would you react and what would you do if you were a member of The Council of the Ohio State Medical Association and had these problems dumped into your lap?

Medicinal Liquor Racket Reviewed—Warning To Doctors

Records of the State Liquor Director reveal that during the past month there has been a sharp increase in the number of prescriptions for medicinal liquor filed with the department by physicians on behalf of patients. Unfortunately, there is some evidence that all of the prescriptions filed are not for sick persons. It looks as if the shortage of liquor for beverage purposes is tempting some citizens and some physicians to resort to the old practices of the prohibition era.

In June *The Journal* published an explanation of the regulations established by the State Liquor Department governing the sale of liquor for medicinal purposes. Following are excerpts from that article. Special attention is directed to the final paragraph:

"*The Journal* suggests to physicians that they not only minimize the prescribing of medicinal liquor but likewise minimize the amounts when prescribing is necessary. If a patient can get along on the regular per capita monthly allowance under the rationing program, additional amounts should not be prescribed. On the other hand, when a physician is of the opinion that a patient's condition would be jeopardized unless an additional amount of medicinal liquor is made available to him or her, he should not hesitate to issue a prescription and submit it to the State Liquor Director. * * *

"To some the regulations issued by Director Fisher may seem unusually stringent but not to those who are informed about the abuses and racketeering which occurred recently in a number of cities when state liquor stores were ordered to sell liquor only on a physician's prescription because of the shortage of liquor for general sale. * * *

"Physicians who practiced during the 'Prohibition Era' will recall the terrific pressure which was put on all physicians to become 'society bootleggers'. No physician who takes pride in his profession or values his personal reputation

will object to reasonable regulations, such as those issued by Director Fisher, which protect the bona fide patient and physician but at the same time will minimize abuses and illegal practices".

Value of Voluntary Plans Substantiated By Figures

One of the main arguments which has been presented in opposition to the Wagner Bill is that which contends that voluntary programs sponsored by private enterprise will be able to solve many of the nation's medical and health programs if ample opportunity is allowed for the creation and expansion of such programs.

There is reason to believe that much can be accomplished, skeptics to the contrary notwithstanding. Let's look at the figures assembled by John R. Mannix, Detroit, director of Michigan Hospital Service (Blue Cross plan) in a report which he made following a survey of voluntary health plans in California.

For purposes of comparison, Mannix pointed out that there are voluntary hospital services plans in operation in 35 states, the District of Columbia and three provinces in Canada. The 35 states and the District of Columbia contain about 90 per cent of the population of the United States and the three provinces about 40 per cent of the population of the Dominion of Canada. Approximately 12½ millions have been enrolled as subscribers.

In analyzing the figures of the various states, Mannix found that the Blue Cross plans in Ohio have enrolled 20.9 per cent of the population of the state, the only state exceeding Ohio being Delaware with a percentage of 22.5. Not so bad over a 10-year stretch, is it?

As to medical service plans—a much newer development in the field of pre-payment health services on a voluntary basis—Mannix found that 12 states have approved medical service plans with subscribers totaling close to 1,000,000. This is a fair beginning over a period of four years, as medical plans were not considered seriously until about 1939.

Those who say that the voluntary methods of providing health services on a voluntary prepayment basis are of little value may have spoken too hastily.

Those who say that the people are not interested appear to be mistaken. The fact that 20 per cent of the people of Ohio think well enough of the idea to enroll in Blue Cross hospitalization plans can't be laughed off.

This approach may be one of the real answers to the Wagner Bill. It's worthy of more serious thought on the part of Ohio physicians than it is now receiving.

What Are You Doing To Scuttle the Wagner Bill?

Judging from the newspaper clippings the Wagner-Murray-Dingell Bill is receiving an airing before plenty of luncheon clubs in all corners of the state. Physicians in counties where the medical profession is keenly aware of the dangers and fallacies of the Wagner proposal are taking the stump and getting good results. Why this isn't being done in all counties has us puzzled. Where does your county line up?

Some of the luncheon clubs have adopted excellent resolutions opposing the bill and, better yet, are having their members make known their views to members of Congress.

A good example of what has been done and can be done elsewhere is the following excerpt from the December 7, 1943, issue of "*Lions Tale*", official publication of the Toledo Lions Club:

"Much interest and concern, together with urges for prompt, protesting action, have come from Lions and guests who heard Dr. Ed McCormick's outstanding talk last Thursday noon on "The Wagner-Murray Bill and Totalitarianism in America.'

"The implications of the $12,000,000,000 program of 'cradle to grave' governmental 'security' for the 130 million Americans seems to be about the last word for rationing all worldly needs . . . doctors, dentists, insurance, employment, old age pensions . . . hospitals . . . everything not already rationed seems to be chucked into Senate Bill 1161, 702 and H.R. 3204 . . . now pending in the Congress.

"Remember what State Treasurer Don Ebright told Lions last May? That unless states and counties shouldered their own responsibilities and started to bring them back home from Washington, we were headed for total bureaucracy . . . 'Totalitarianism in America' Ed McCormick calls it . . . and points to the fact that employees in government bureaus have increased 700 per cent faster than the population . . . and Ed makes it look like this Wagner-Murray-Dingell bill is the last straw.

"And if you feel towards Messrs. Wagner, Murray and Dingell as some Lions have already expressed themselves, and want to do some protesting while there is still time, write the following gentlemen from Ohio a nice letter. They'll be mighty glad to hear from the home folks before Christmas:"

(Appended were the names of a number of Northwestern Ohio Congressmen and Ohio's two U.S. Senators).

You may not be an orator but you can do much good by helping circulate the pamphlet, "No! The Wagner Bill Is Not the Answer!", prepared by the Ohio State Medical Association and copies of which may be obtained from the Secretary-Treasurer of your County Medical Society.

Doctor: Have you written your Congressman to send you a copy of the Wagner-Murray-Dingell Bill (S. 1161)? Have you let him know what you think of that bill?

WAR NOTES

"Proudly we hail" Lt. Col. P. F. Briola, Cleveland. He has been awarded the Legion of Merit medal for "exceptionally meritorious conduct in the performance of outstanding services" during the New Georgia-Munda campaign in the South Pacific. At the time of the announcement, Lt. Col. Briola was in a base hospital recovering from illness.

His citation reported: "As regimental surgeon, Col. Briola's thorough training of his personnel and painstaking advance planning made possible a highly efficacious medical service throughout hostilities (from July 20 to August 5).

"Although constantly harassed by enemy fire, inclement weather and arduous terrain, this officer and his personnel administered to the medical needs of 15 officers and 400 enlisted men with such alacrity and dispatch as to inspire all the fighting men with confident assurance and high morale.

"Performing his own duties with exemplary courage and devoted efficiency, Col. Briola inspired his men to expend their best efforts and thus contributed inestimably to the success of combat operations".

He has served in the Army for three years and as regimental surgeon of the 145th Infantry of the 37th Division he went overseas 18 months ago. Formerly he served as house doctor at St. Alexis Hospital and resident at Lakewood Hospital.

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A native of Blanchester, and graduate of Ohio State University College of Medicine in 1942, Lt. Guy Irvin, Jr., was given special mention by a Chicago Daily News correspondent recently, for distinguished service with an advanced platoon in a field hospital only a few miles behind the front in Italy.

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The War Department, Washington, D.C., appreciating the advance made in recognizing and treating symptoms calling for specialized handling by psychiatrists of personnel in the armed forces, is revising tables of organization to include a neuropsychiatrist, to be assigned automatically to every division. He will be a member of the division surgeon's office and will advise the division surgeon along the line of his specialty. He is to have the rank of captain or major... During the training period of troops, the division psychiatrist will be expected to detect, treat and eliminate actual and potential neuropsychiatric cases. In addition, he will instruct all officers of the division in the recognition, prevention and treatment of mental casualties. In combat zones it will be his duty to sift and clear casualties of this type, with the object of returning to duty all personnel possible.

The Journal of the American Medical Association for December 4 says:

"With the beginning of the Selective Service examinations the importance of preliminary neuropsychiatric study became clear. Just recently the Selective Service Administration has improved its technic for this purpose.

"Up to April, 1943, almost half a million men had been rejected for psychiatric reasons. About one-third of all casualties now being returned from overseas are neuropsychiatric. The strain of this war affects leaders, with the added stress of leadership, even more than it does the men in subordinate rank. Already it is clear that constant attendance by qualified neuropsychiatrists may serve to detect potential breakdowns among aviators and to restore men in such condition to active service far more quickly than would otherwise be the case."

Paper restrictions may curtail the size of The Journal, but the extent of the "War Notes" section is limited only by the news available. Sources are personal letters, newspaper clippings and local Academy bulletins. Physicians in the service and those at home are all eager for news about their colleagues on military duty. The Journal solicits such news.

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Capt. George B. Watson, Columbus, is now on the staff of the Ashburn General Hospital, McKinney, Texas. He was previously stationed at Skagway, Alaska, and Seattle.

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The Office of the Surgeon General of the Army has notified the Service Commands that "Due to shortage of medical corps officers they will not be ordered before retiring boards unless they are totally disabled for all types of duty. Greater care will be exercised in marking medical corps officers 'Limited Service'. Advantage will be taken of reviewing any limited service officer's cases who may be marked 'Full Military Duty'."

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Extract from letter written by Capt. M. B. Taliak, Cleveland, attached to the 8th General Hospital, A. P. O. 502, c/o P. M., San Francisco: "We are short of medical officers and consequently have to put in a little overtime, but that's O.K. They tell me some day we'll be getting double time. Many of our boys are from the old home town and I feel pretty good about taking care of them. Several live in Lakewood, Berea, Willoughby, East Cleveland, and surround-

ing communities. They have been through a very rugged campaign and many are going back home soon. Yes, you never know who you'll meet over here, even Eleanor. But she made a deep impression here. Lanny Ross likewise. Their efforts seem so minute, but everyone wishes there were more like them. Life becomes pretty stale unless a little variety creeps in once in a while. Jungles are not the most glamorous place to be unless a Dorothy Lamour was back of every tree. The boys tell me it isn't so."

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Three Ohio physicians are on the staff of the Foster General Hospital which was formally dedicated at Jackson, Miss., on September 18. They are: Major Reubin R. Pliskin, Akron, assistant chief, medical service; Capt. Edward B. Weinman, Steubenville, surgical service; Capt. Harry J. Keys, Columbus, post surgeon. The hospital is of semi-permanent brick construction with a total bed capacity of 1,768.

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The Purple Heart for wounds received in the African campaign and the Silver Star for gallantry in action were recently awarded Capt. Frederick R. Tingwald, Youngstown, according to word received by his wife. He was a member of the invasion forces landing in North Africa, Nov. 8, 1942, and is reported fully recovered from his wounds.

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One of the members of the Lakeside Unit, now in Australia, was lauded in the press of that country for the performance of a rare heart operation which saved the life of a two-year old boy. The surgeon was Capt. Paul Gebauer, demonstrator in surgery at Western Reserve University until he went into the service two years ago.

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Major Robert Holmberg, now on duty in England, reports that he has been in London quite a few times and last March attended a course of lectures and demonstrations at the London School of Hygiene and Tropical Medicine. He is with a fighter squadron of the AAF.

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Commissioning of the U. S. Army hospital ship *Seminole* was recently announced by the War Department. A former combination freight and passenger ship, the vessel is 402 feet long and has a gross tonnage of 5896 and a net tonnage of 3514. It contains 284 beds for bed patients and 182 beds for ambulatory patients. The ship is staffed by 15 medical officers, 30 nurses and 81 medical attendants. In addition it has a Navy crew. The commanding medical officer is ship commander, but navigation is under command of a naval officer. The Army has two other hospital ships in operation, the *Acadia* and the *Shamrock.*

Two Toledo physicians are in charge of a School of Anesthesia—the first of its kind in the Army Air Forces—which has been established at the Station Hospital, BTC No. 10, AAFTTC, Greensboro, N. C. The 90-day course was opened last month to make medical officers in the AAF thoroughly familiar and adept in the use of anesthesia agents and methods found to be most suitable for combat zone areas. The school is directed by Maj. F. W. Clement, who served with the British and Canadian armies from 1914 to 1920. He was at Gallipoli, in Egypt, Africa, France and Belgium. Associated with him is Capt. M. P. Cooper, transferred recently from Sioux Falls, S. D., where he was chief of anesthesia at the Station Hospital.

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Woman doctors in the Navy will not be assigned to overseas duty, duty on naval craft or in combat aircraft, according to HR 2859 signed by the President on November 10.

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The United States News estimates that already 800,000 men have been released from the armed forces, and that the rate will be around 75,000 per month as the war moves into the new year.

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Major A. O. Diggs, Mansfield, writes that he too appreciates receiving *The Journal.* He is regimental surgeon for the 25th Infantry, APO 93, Los Angeles 52, Cal.

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Lt. R. E. Wetzel writes from the South Pacific: "I am the only Akron man in this outfit, although there are several from the Cleveland Clinic. Work is plentiful, varied and interesting. We have our own Island Medical Society here with meetings and everything. But recreational opportunities are few. While this is a typical Hollywood tropical isle, complete with palms, beaches, moon and stars, the Hollywood type sarong girls, sad to state, are missing." So we've heard before, doctor!

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Major Ivor McIvor Campbell, Akron, is a group flight surgeon in England. Dr. Campbell went across originally in the Medical Branch of the Royal Canadian Air Force, and later was transferred to the AAF.

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Notes on Columbus physicians in the service. . . . Dr. John E. Martin was recently promoted to the rank of Captain. He is a squadron surgeon with the Air Force in England. . . . Capt. Willard B. Andrus has been transferred from Camp Carson, Col., to the Army Medical Center, Washington, D.C. . . . Capt. Albert Kostoff, Camp Dix, N.J., reports a reunion with two other Columbus Academy members: Lt. Comdr. Harvey Clodfelter and Capt. Thomas E.

Rardin, at the meeting of the Association of Military Surgeons in Philadelphia in October. . . . Capt. John Q. Brown is reported to be on the West Coast, destination unknown. . . . Major Richard C. Carlisle has been transferred from the Medical Research Laboratory at Edgewood Arsenal, Maryland, to the Toxicological Research Laboratory.

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Lt. Col. William R. Hallaran, Cleveland, now on duty at the McCloskey General Hospital, Temple, Texas, has been awarded the Legion of Merit medal by General Douglas MacArthur, according to word received by his mother. The citation was for exceptionally meritorious conduct in the performance of outstanding service in New Guinea. As surgeon of an advanced base, Col. Hallaran maintained the health of the command by his tireless supervision of malaria control activities, and by his development of field sanitation technique, effectively adapted to troops in the jungle, the award stated.

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Major Harold K. Goler, Cleveland, now assigned to the Station Hospital, Fort Lewis, Wash., writes that while it wasn't too much of hardship being in the Hawaiian Islands, it certainly is good to get back to the mainland. Like many others, Dr. Goler says he has enjoyed receiving *The Journal*, particularly the War Notes. (By the way, we'd have more War Notes if more Ohio doctors would let us know what they're up to).

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Major James K. Nealon, urologist for the Army Air Forces Technical Training Command, Sioux Falls, South Dakota, writes that he is interested in the article appearing in *The Journal* on the Wagner-Murray-Dingell Bill. Glad to hear that you are, Doctor, and so should the other physicians in the service. Prohibition was adopted during World War 1.

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October 9 was the proverbial red letter day for Mrs. Betty Cable Kuby, Cincinnati. Her daughter was born that day—and she received a letter from her husband, Capt. William H. Kuby, now serving in the Mediterranean Area, that he had been awarded the Silver Star for galantry in action. Capt. Kuby was an intern at the Cincinnati Jewish Hospital when he entered the Army 16 months ago.

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News of some Youngstown physicians in the service . . . Major Asher Randall is at the Signal Depot, Lexington, Ky. . . . Lt. Stan Myers reports that he is back in civilization again after 14 months in the Islands", (Don't know what "civilization" or what "islands"). His address is U.S.N. Base Hospital No. 4, Navy 133, Fleet P. O., San Francisco. . . . Lt. Myers says that Al Cukerbaum is with him—and that they see Bill Evans occasionally . . . Major Louis R. Kent is somewhere in England.

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Another Akron physician, Lt. H. G. Lieberman, has been overseas since April. He took part in the Tunisian, Sicilian and Southern Italy invasions.

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Capt. Nathan Gordon recently enjoyed a month's sojourn at his home in Akron after 18 months' duty as roentgenologist at a station hospital on the island of Trinidad. He is now back at his post in Trinidad.

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Major General James Carre Magee, Medical Corps, United States Army, retired, formerly Surgeon General, has been named executive officer of the information service of the division of medical sciences of the National Research Council. He will devote full time to the organization of a central office in the National Research Council which will collect medical reports and records, widely dealing with military medical practice, civilian practice as affected by the war, medical education and research and the distribution of diseases. This material, so far as military necessities permit, will be available by publications, summaries and notes. This service has been established by the Council under the recent grant of the Johnson & Johnson Research Foundation of New Brunswick, N. J., by which $75,000 was made available.

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The next time you see Lt. Col. Claude S. Perry, Columbus, chief of EENT, McGraw General Hospital, Walla Walla, Wash., ask him about that hold-up experienced in Portland, Ore.

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Capt. Lambert J. Agin, a graduate of the Ohio State University College of Medicine in 1939, was recently home at Cincinnati on a short leave from Rhodes General Hospital, Utica, N. Y., where he has been convalescing. Capt. Agin was stricken with pneumonia while on duty in Sicily as a Flight Surgeon with the Twelfth AAF Transport Command. Capt. Agin was resident physician in Ophthalmology at Henry Ford Hospital, Detroit at the time of enlistment. He went overseas in September, 1942. After spending two months in England, he landed with the invasion forces at Oran, and later went to Tunisia and Sicily.

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Another Ohio physician has been decorated. Capt. Louis Kreindler, Cincinnati, has been awarded the Legion of Merit, the U. S. Army headquarters in the South Pacific recently reported. The citation stated that Capt. Kreindler

has received the award for "exceptionally meritorious conduct in the performance of outstanding services at Guadalcanal during the period of January 10 to Feb. 9. His services were outstanding in that he accomplished the work without the allotted officer personnel and only a fraction of the enlisted personnel. As commanding officer of the collecting company, he completed its organization and training and was responsible for the skillful and efficient evacuation service rendered by this unit during the combat period on Guadalcanal". According to news accounts, Capt. Kreindler on one occasion saved the life of a native chieftain, whereupon he was offered one of the chief's several wives. A graduate of the University of Cincinnati College of Medicine, Capt. Kreindler enlisted shortly after completing his internship at the Cincinnati Jewish Hospital in December, 1940, and was stationed at Pearl Harbor during the attack by the Japanese.

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Lt. Comdr. Norman J. Birkbeck met his 15-month old daughter Gayle for the first time recently when he returned to Dayton after 18 months in the South Pacific attached to the Dayton Naval Specialist's Unit. Dr. Birkbeck has been assigned to the X-ray department of the Great Lakes Naval Hospital. The majority of the nine men attached to the original group have returned to this country. Besides Dr. Birkbeck, Lt. Comdrs. Jerome Hartman, Lawrence Patterson, Arthur M. Culler and Thomas P. Sharkey are here.

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His fiftieth jump as a paratroop surgeon brought Major H. R. Rossmiller his gold wings, he recently reported from North Africa. Writing to his former colleagues in Cleveland, Major Rossmiller said in part: "Mail continues to be a leading pleasure out here. After this length of time I must say that this place begins to take on certain characteristics which make it seem like home until one receives a letter or so. My French has made a little progress recently, as I am able to ask for the things one runs into in everyday life. Weather is quite cool now. Sleeping with two blankets."

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Dr. James A. Doull, recently returned from a special mission in the South Pacific for the U. S. Public Health Service, spoke on health in Australia and New Zealand at the third anniversary of the Cleveland Health Museum.

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Mobile Naval hospital units in the South Pacific were credited with saving many lives in a recent dispatch from Tech. Sgt. Jim G. Lucas, Marine Corps Combat Correspondent. You Ohio doctors "way down under", how's for a report on your activities?

Major General Norman T. Kirk, Surgeon General of the Army, has appointed a special board of medical officers to study the clinical treatment of malaria. Two hundred beds were ordered set aside for that purpose in each of the following general hospitals: Bushnell (Brigham, Utah); Harmon (Longview, Texas); Kennedy (Memphis, Tenn.); and Percy L. Jones (Battle Creek, Mich.).

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Home on sick leave after caring for members of Ohio's 37th Division on the Mundy battle-front, Dr. Lawrence B. Lazarus, Cleveland, praised the Army Medical Corps transport service for keeping the mortality rate extremely low in the South Pacific by quick transfer of seriously wounded soldiers to ships and flying boats.

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Graduation exercises were held on October 27 for aviation medical examiners following the course in aviation medicine, which is now given in its entirety at the School of Aviation Medicine Randolph Field, Texas. This is the first class to complete this changed program which began on August 26. Among the graduates were the following medical officers from Ohio: Lt. Edwin H. Artman, Chillicothe; Capt. William W. Corwin, Galion; Lt. Philip B. Demaine, Akron; Capt. Benjamin S. Gillespie, Barnsville; Lt. Donald O. Nellins, Cleveland; Major Ervin S. Ross, Cincinnati; Capt. Joseph R. Schauer, Dayton, and Lt. Lester L. Williams, Mt. Vernon.

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Capt. Garry G. Bassett, Cleveland, sent Christmas greetings to *The Journal* from APO 730, c/o PM Seattle. He is with the 29th Field Hospital.

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A recent issue of The Phi Gamma Delta magazine disclosed that Capt. Robert C. Haubrich, Pataskala, is with an AAF unit in Hawaii. He appears in a picture of a reunion of that fraternity in Honolulu.

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About Miami County physicians. . . . Capt. Harry E. Shilling, Troy, is in the "cold and dreary North Pacific" . . . Perhaps dreary, but certainly not cold is the location of Capt. Emory R. Irvin, Bradford, in the desert between Yuma and Phoenix. . . . Major B. E. L. Hyde, Troy, is busy with desk duties in New Orleans. . . . "If you want to really do medical work, don't be promoted above the rank of captain", he says. A later report brings news that Major Hyde has been promoted to the rank of Lt. Col., and is now Executive Officer of the Station Hospital, Port of Embarkation, New Orleans . . . Major Hugh Wellmeir, Piqua, was on detached duty from Comp Breckinridge, Ky., attending the recent meeting of the American Academy of

Pediatrics in Cincinnati . . . Capt. Wm. V. Trostel, Piqua, now on duty at Tampa Fla., spent a short leave at home during the hunting season.

* * *

News from some Toledo physicians in the service. . . . Major O. E. Todd, at the Air Base, Alliance, Nebr., likes his post but anticipates a transfer. . . . Major A. J. Kuehn is in Oxford, England, assigned to the 2nd General Hospital—the Presbyterian Unit from New York City. . . . "Cy' writes that he considers himself fortunate to be working with this group "even if it is probably only for a short time". . . . Major Maurice A. Schnitker at the Valley Forge General Hospital, Phoenixville, Pa., says he's for the current drive to build up the library of the Toledo Academy and mentions the arrival of a 6½ pound son on November 15. . . . Lieut. Comdr. Spencer W. Northrup, with Fleet Air Wing 17, Navy 421, Hawaii, reports to Dr. Karl Figley that "we do have hay fever, both here in the Southwest Pacific and in Hawaii".

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Capt. Raymond S. Lord, Fredericketown, is reported to be with a hospital unit in Iran.

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Decorations have been awarded to Lt. David C. James, M.C., U.S.N.R., of Caruthersville, Mo., formerly of the Cleveland City Hospital house staff. Dr. James has been awarded the Navy and Marine Corps medal for outstanding bravery in action against the Japanese. A citation, signed by Admiral W. F. Halsey, accompanied the medal. It stated in part:

"For heriosm while serving as medical officer on board a tank landing ship operating in the New Georgia area on Aug. 18. Lt. James with complete disregard for his own personal safety, entered the troop berthing compartment to supervise and assist in the rescue of an injured shipmate who was pinned down under derbis following an explosion. His courageous conduct was in keepng with the highest traditions of the United States naval service".

* * *

Capt. Jos J. Levin, Canton, now a surgeon with a Field Hospital in New Guinea, V-mail's that he anxiously awaits each issue of *The Journal* for news of his classmates and friends.

* * *

Apologies to Major David C. Frick, Toledo. Of all things, *The Journal* got ahead of the War Department. In the December issue, it was noted that Dr. Frick had been promoted to Lt. Col. Actually the boost was to Major. Dr. Frick is due to complete the Aviation Medical Examiners Course at the School of Aviation Medicine, Randolph Field, Texas on January 6. He expects to return to his former post at Hq. AAF, Office of Flying Safety, Winston Salem, N. C.

* * *

Major Alvin J. Swingle is executive officer of the 58th General Hospital, now in England. A native of Zanesville, Dr. Swingle graduated from the Ohio State University College of Medicine in 1938. He was practicing in Mandan, N.D., before entering the service.

* * *

Medics in the 37th (Ohio) Division should take a bow. They were singled out for special praise in the War Department's report on the campaign on New Georgia Island in the South Pacilc last summer. Said the report: "Testimony to the efficiency of the division surgeon's office is the fact that less than one per cent of the total number of casualties evacuated to the field hospital died of wounds. Furthermore, in the entire combat period but five men from the division contracted malaria. This record was due to the care and attention given the men by Lieut. Col. Hobart L. Mikesell, West Liberty, and his assistant, Maj. Harold J. Barker, Cleveland Heights."

Col. Mikesell returned to Ohio on sick leave in November. He addressed a number of bond rallies and also the wives of the officers of the 37th Division.

* * *

Capt. R. W. Pocotte, Toledo, is with the 118th Station Hospital in Italy. He has seen Capt. John M. McWilliams, also of Toledo, and Capt. Wm. E. Russell, formerly of Genoa, Ottawa County.

* * *

Major Robert E. Bowsher, Toledo, now heads the Huntington, W. Va., Induction Station. He was recently promoted to his present rank.

Dr. Dittrick Takes Clinic Position

Dr. Howard Dittrick, Cleveland, retired from private practice December 1 to accept an appointment at the Cleveland Clinic Foundation. He will have charge of editorial work, exhibits, museums, library, art, and photographic department of the clinic and will be secretary of the Frank E. Bunts Educational Institute. Dr. Dittrick will continue as editor of the *Bulletin of the Academy of Medicine of Cleveland;* directing editor of *Current Researches in Anesthesia and Analgesia* and as attending physician to the student health service at Western Reserve University.

Wilmington—Dr. Robert Conard pointed out what the passage of the Wagner Bill would mean to the American people at a meeting of the Rotary Club.

Do You Know - - -

His work the past six years against the nutritional deficiency diseases won for Dr. Tom D. Spies, associate professor of medicine, University of Cincinnati College of Medicine, the research medal of the Southern Medical Association at its recent annual meeting in Cincinnati.

* * *

More Americans have lost their lives in fires since 1900 than have been killed in all the wars fought by the United States, according to a recent announcement of the National Fire Protection Association. It is estimated that 425,000 persons have died as a result of fires in this country since the turn of the century.

* * *

February 2 has been designated as Social Hygiene Day by the American Social Hygiene Association.

* * *

With the recent death of Fred R. Schaefer, 49 years old, Columbus, who was injured in 1926, it was revealed that expenditures in his behalf by the State Industrial Commission, totaled $90,000 for compensation, medical and hospital expenses. He was completely paralyzed, and hospitalized for 14 years.

* * *

If you have any suggestions for simplifying tax returns and the internal revenue code, send them to Colin Stam, chief of staff, Joint Committee on Internal Revenue, New House Office Building, Washington, D.C.

* * *

According to the Joint Committee on Reduction of Nonessential Federal Expenditures, of which Sen. Harry F. Byrd, Democrat of Virginia, is chairman, Uncle Sam now owns one-fifth of the entire land area of the continental United States.

* * *

Thos. P. Kearns, superintendent of the Division of Safety and Hygiene of the State Industrial Commission since its organization in 1925, retired on November 15. His successor is Harry L. Sain, Columbus, previously assistant superintendent.

* * *

Dr. Edward D. King, associate professor of otolaryngology of the University of Cincinnati College of Medicine, and former president of the Cincinnati Academy of Medicine, has been named by Governor John W. Bricker to the nine-member commission created at the last session of the Legislature to acquire new sites and construct new schools to house the state blind and deaf institutions.

Medical science must focus its attention on the prevention and treatment of ailments of old age, Dr. Roy W. Scott, professor of clinical medicine, Western Reserve University School of Medicine, told 79 graduates at the recent Commencement exercises of the University of Cincinnati College of Medicine.

* * *

Mac F. Cahal, executive secretary of the American College of Radiology, Chicago, has been appointed executive officer of the Southwestern Medical Foundation, Dallas.

* * *

According to the Bureau of the Census, there were 36 deaths from rabies reported for the entire United States in 1942. Four of these occurred in Ohio.

* * *

There are three stillbirths for every 100 babies born alive, according to the Statistical Bulletin of the Metropolitan Life Insurance Company, and a total of about 75,000 stillbirths a year in the United States. The ration of stillbirths to live births has reduced by nearly one-fifth in the past decade.

* * *

Mary A. Jamieson, R.N., who until August 1 was hospital and patient inspector of the State Industrial Commission, has re-entered the hospital field as superintendent of the Memorial Hospital, Piqua. Miss Jamieson is a past president of the Ohio Hospital Association and at one time was superintendent of Grant Hospital, Columbus.

* * *

Following a special meeting of the Board of Directors of The Upjohn Company, Kalamazoo, Michigan, President Donald S. Gilmore announced that G. V. Patterson, Vice President and Director of Sales, was made Vice President and Director of Production, and E. H. Schellack was elected to the Board of Directors and was made Vice President and Director of Sales. The untimely death of Dr. Harold S. Adams, recently elected Vice President and Director of Production, precipitated this action.

* * *

The establishment of a center for the scientific study and development of physical medicine as a branch of medical practice was announced recently by Basil O'Connor, President of the National Foundation for infantile Paralysis. The center will be in the Graduate School of Medicine of the University of Pennsylvania at Philadelphia. The Foundation has made a grant totaling $150,000 for a five-year period from January 1, 1944 to December 31, 1948.

Mid-Winter Examinations Given by State Medical Board To Large Group in Columbus, December 13-16

LICENSES to practice medicine and surgery in Ohio were sought by 246 medical school graduates at the Mid-Winter meeting of the State Medical Board, December 13-16, at Columbus.

Sixteen applicants were examined in osteopathy and surgery. In addition 160 osteopaths, previously licensed in Ohio, sought licensure in accordance with the provisions of Sub. H.B. 112, which became effective July 30, 1943, after having been passed by the Ohio General Assembly last Spring. Examinations for certificates of limited practice were taken by 7 chiropractors, 25 mechano-therapists, 12 chiropodists, 13 masseurs and 3 cosmetic therapists.

Results of the examinations will be announced at the meeting of the Board to be held in Columbus February 8.

Following are the questions asked those who were examined for licenses to practice medicine and surgery:

ANATOMY

1. Give the anatomical structure of the inguinal canal.
2. Give the shape, dimensions, innervation and relation of the Eustachian tube.
3. Discuss the sensory innervation of the peritoneum.
4. Describe the anatomy of the sacro-iliac joint.
5. Describe the relations of the levator and muscles.

PHYSIOLOGY

1. Give the physiology of normal hearing.
2. Discuss the function of the pancreatic secretion in digestion.
3. Give the physiological significance of blushing.
4. Discuss the physiology of muscular fatigue.
5. Give the physiology of normal menstruation.
6. Describe blood oxygenation during normal respiration.
7. What are the functions of the supra-renal glands?
8. What are the functions of the thyroid gland?
9. Discuss nerve reflexes—giving uses in diagnosis.
10. What is the function of the gall bladder?

DIAGNOSIS

1. Give signs and symptoms of acute lymphatic leukemia.
2. Differentiate signs and symptoms of typhoid fever, undulant fever, and malaria, with laboratory tests.
3. Give signs and laboratory tests in subacute bacterial endocarditis.
4. Differentiate acute right salpingitis, acute appendicitis, and right tubal pregnancy.
5. Give signs and symptoms of labor pneumonia and virus pneumonia.
6. Differentiate scirrhus (hypertrophic) passive congestion and large liver due to blocking of hepatic duct.
7. Describe symptoms of coronary occlusion and differentiate from gall stone occlusion of cystic duct.
8. Differentiate Vincent's angina and Ludwig's angina.
9. Give symptoms of primary and secondary anemia, with blood findings in each.
10. Differentiate meningitis and acute anterior poliomyelitis

CHEMISTRY

1. What is the action of insulin?
2. Describe lactic acid. Give cause of its presence in the stomach. Give a test for its detection.
3. What is glycogen? From what is it derived? What is it converted into by dilute acid?
4. When is diacetic acid found in urine? Give a chemical test.
5. What is meant by pH and what is normal pH of—(a) blood, (b) urine?

MATERIA MEDICA AND THERAPEUTICS

1. Compare the actions of digitalis and quinidine on the human heart in a state of auricular fibrillation.
2. How does morphine affect (a) intestines (b) pulmonary edema (c) circulation? How do morphine and cocaine act to relieve or prevent pain?
3. Discuss carbon tetrachloride (C Cl 4) as to: (a) therapeutics (b) toxicology and treatment of acute poisoning.
4. What therapeutic agents are used in treating shock? Tell how each agent acts.
5. Name three respiratory stimulants. Give action and dose of each. Name three respiratory depressants. Give antagonist of each.
6. Name three drugs indicated in bronchial spasm. Name three drugs indicated in cardiac asthma. Give action and dose of each drug.
7. What chemical agents increase intracranial pressure? What chemical agents lower intercranial pressure?
8. How do (a) codeine (b) ipecac (c) potassium iodide act to allay a cough?
9. What is testosterone propionate? In what condition is its use indicated?
10. What is penicillin? How prepared for use in medicine? What are its indications?

MATERIA MEDICA
(Homeopathic)

1. How are tinctures made? How standardized? What is the distinguishing characteristic of green plant tinctures?
2. Definite polycrest. Nosode. Attenuations. Modalities. Drug proving.
3. Give source and keynote symptoms of cortalis horidus.
4. Name and give leading symptoms of two remedies used in edema.
5. Name and differentiate four remedies indicated in influenza.
6. Compare mental symptoms of belladonna. Chamomilla. Pulsatilla.
7. Name and give characteristic symptoms of four remedies to be used in colitis.
8. Give five remedies to be used for pain with differentiating symptoms of each.
9. Write a prescription for an opiate in a case of fracture.
10. Name five remedies frequently used in pertussis, with indications for each.

PRACTICE

1. What is meant by vitamin deficiency? Name 3 examples with symptoms of each and treatment indicated.
2. Give the etiology, symptoms and treatment of meningococcic infection.
3. Discuss angina pectoris as a disease or syndrome, possible pathology in some cases, symptoms and treatment.
4. Give the etiology, symptoms and treatment of chronic gallbladder disease.
5. Discuss the etiology, symptoms, clinical course and management of a case of chronic diffuse glomerulonephritis.

PATHOLOGY

1. Name 5 pathologic constituents that may be found in the stools and how may they be recognized?
2. Discuss "blood typing", methods employed and reasons for its use.
3. Give the pathologic differentiation between a cyst of the breast and an early carcinoma.
4. Describe the pathology of chronic endocarditis involving the mitral valve and the consequent changes in the heart as a whole.
5. What pathology may result in the brain as a result of arteriosclerosis?
6. Give the most common cause of a massive hemorrhage from the esophagus and discuss the pathology present.
7. Discuss the pathology of an enlarged prostate causing urinary obstruction in an elderly man and differentiate between two probable conditions.
8. Discuss the pathology in the cord in poliomyelitis and in locomotor ataxia and the relation of the changes to the characteristic neurologic symptoms.
9. Discuss "Banti's disease" in respect to its pathologic course in an unfavorable case.
10. Describe the blood picture in (a) pernicious anemia, (b) lymphatic leukemia, (c) epidemic mononucleosis, (d) aplastic anemia and (e) sickle anemia.

SURGERY

1. What is the difference between pelvic inflammatory disease, pyosalpinx and broad ligament abscess? Under what conditions is the latter most likely to occur?
2. Describe the process of wound repair of intestines.
3. In laceration of flexor surface of wrist, with severance of some of the flexor tendons, detail method of management.

4. Give the treatment of a case of a penetrating gunshot injury of the chest. (The wound entrance of the projectile is situated in the fifth interspace right side mid-axillary line.)
5. Discuss the principles involved in the treatment of a simple oblique fracture of the femur at about the junction of the middle and lower thirds.

OBSTETRICS AND GYNECOLOGY

1. Discuss the placenta as to (a) anatomy (b) function (c) pathology.
2. Give the causes, prevention, and treatment of complete tears of the perineum.
3. What are the predisposing causes of occiput posterior presentation of the fetus at term?
4. What may cause uterine bleeding after the climacteric? Discuss treatment.
5. Discuss the etiology, pathology, and treatment of intracranial hemorrhage of the new-born.

SPECIALTIES

1. Give the diagnostic signs and treatment of suppurative otitis media.
2. Define Strabismus. Iritis.
3. Outline treatment of latent syphilis.
4. What is scurvy? How may it be prevented?
5. Give treatment of trench mouth.

PREVENTIVE MEDICINE

1. Discuss the possibility of malarial outbreaks in this country as a post-war result and indicate preventive measures.
2. Outline procedures to control and eradicate diphtheria in a community.
3. What measures would you institute to control the spread of poliomyelitis?
4. Give etiology of septic sore throat and your advice to prevent its spread.
5. Give mode of transmission of the following:
   a. yellow fever
   b. malaria
   c. typhus fever
   d. typhoid fever
   e. amebic dysentery

BACTERIOLOGY

1. Discuss the method of examining the sputum with special reference to two important pathogenic bacteria and associated pathologic material present which may throw light on the stages or progress of the disease.
2. Give the methods of recognizing chronic carriers of (a) diphtheria (b) typhoid fever and (c) malaria.
3. Name 3 organisms that may cause meningitis, and in a suspected case, describe methods of establishing the diagnosis.
4. Give the cause and method of transmission of (a) undulant fever (b) tularemia and (c) Rocky Mountain fever.
5. Name 3 diseases that may be recognized by blood culture and describe technic.
6. Name 3 diseases that may be recognized by serological agglutination tests and describe method in each.
7. Describe the Gram method of staining and for what purpose is it used?
8. Define aerobic and anerobic bacteria with two examples of each.
9. Give two examples of spore bearing pathogenic organisms and discuss the influence of that bacterial property in disease production.
10. Define immunity, active and passive, sensitization, droplet infection, ptomaine poisoning, and antigen.

Coming Meetings

Ohio State Medical Association, Columbus, May 2-4, 1944.

American Medical Association, Chicago, June 12-16, 1944.

Annual Congress on Medical Education and Licensure, Chicago, Feb 14-15.

Annual Forum on Allergy, St. Louis, Jan. 22-23.

Columbus—"The Truth About Vitamins" was the topic discussed by Dr. Jonathan Forman at a meeting of the Optimist Club.

Canton—A two-story nurses' home and a 50 bed addition for Aultman Hospital is to built at a total cost of $248,000.

New Army Hospital Train Viewed in Cincinnati While Enroute West

Many Cincinnati physicians accepted the invitation of Col. E. C. Jones, M.C., U. S. A., Surgeon for the Fifth Service Command, to inspect the first overseas type hospital train built in the United States, which stopped off in Cincinnati November 28 en route to the Desert Training Center, Banning, California. Designed specifically for use in combat areas, this ten-car train will be used temporarily for training personnel in the operation of such units.

The all-steel-train built a cost of $135,000 by the Pullman Company, consists of six ward cars for patients, a kitchen car, utilities car, and two personnel cars for officers and enlisted men. Personnel includes four officers, two of whom are doctors, two medical administrative officers, six nurses, including one chief nurse, and 33 enlisted men, all of whom are technical specialists trained in medical work, or other duties essential to the operation of the train unit.

Trains of this type are to be used for removing wounded and sick from evacuation hospitals, which are usually within 25 to 50 miles of the front lines, to the larger general hospitals several hundred miles in the rear.

The train operates as a complete unit within itself. Heat, light, hot water, ventilation and refrigeration are supplied from generators and oil-fired boilers in the utilities car. It is illuminated throughout with fluorescent lamps. Messing facilities are provided in the kitchen car where a dinning compartment will accommodate 16 members of the train's operating personnel. Patients are served from trays. A pharmacy department is located in one end of the kitchen car where all medical supplies and drugs are kept.

The six ward cars each provide berths for 16 bed patients, or more ambulatory patients with the double-decker berths folded down. In the center of each ward car is an emergency operating area, a cleared space free of berths. Stretchers may be carried into the train through double-size doors in the center of the car, placed on portable standards, and used in emergency as an operating table without transfer of the casualty. In combat areas it is anticipated that the train will have 16 ward cars. It is reported that orders for additional hospital trains will be announced shortly.

Sandusky—"Eating in War Time" was the subject of an address made by Dr. Jonathan Forman, Columbus, at a public meeting in the local high school sponsored by the Erie County Nutritional Council.

Toledo—Dr. Edward J. McCormick pointed out the implications of the Wagner Bill at a meeting of the Lions Club.

In Memoriam

James M. Bowman, M.D., Columbus; Ohio State University College of Medicine, 1916; age 65; former member of the Ohio State Medical Association and the American Medical Association; died November 21. A native of Adams County, Dr. Bowman practiced in Columbus for 26 years. He was in the Medical Corps of the U. S. Army during World War 1. Surviving are his widow, a brother and four sisters.

Allen W. Budd, M.D., Canton; Western Reserve University School of Medicine, 1880; aged 91; former member of the Ohio State Medical Association and the American Medical Association; died December 10. Dr. Budd retired in 1927 after having practiced ten years in Northfield and for 37 years in Ashland County. Surviving are his widow, a daughter and two sons, including Dr. Harold A. Budd, Cleveland.

Lila Owen Baker Burbank, M.D., East Liverpool; Tufts College Medical School, 1903; age 73; died November 19. Dr. Burbank practiced for many years in Boston, Mass. A son and a brother survive.

William Sabin Chase, M.D., Akron, University of Michigan Medical School, Ann Arbor, 1901; aged 77; former member of the Ohio State Medical Association and the American Medical Association; died December 1. Recently in ill health, Dr. Chase had practiced in Akron for over 40 years. He was one of the founders of Peoples and Childrens Hospitals. His widow, two daughters and a sister survive.

Charles Curtis Jones, M.D., Cincinnati; University of Cincinnati College of Medicine, 1910; aged 56; member of the Ohio State Medical Association; Fellow of the American Medical Association and diplomate of the American Board of Otolaryngology; died November 22. Dr. Jones was on the staffs of Bethesda and Christ Hospitals and practiced in Cincinnati for 23 years. He was a member of the Norwood Board of Health, the Norwood Club, the Cincinnati Optimist Club; a past-president of the Norwood Parent-Teachers Association and in charge of the medical division of the Norwood civilian defense. Surviving are his widow, two daughters, and a son.

Benjamin Harrison Lamb, M.D., Cincinnati; University of Cincinnati College of Medicine, 1915; aged 54; member of the Ohio State Medical Association and Fellow of the American Medical Association; died November 23. Dr. Lamb practiced in Cincinnati for over 25 years. During World War I he served with the Royal Army Medical Corps of the British Army. Surviving are a son, two sisters and two brothers.

Thomas Addison McCann, M.D., Dayton; Hahnemann Medical College and Hospital, Philadelphia, 1891; aged 84; died November 7. Dr. McCann retired five years ago after having practiced in Dayton for nearly 50 years. He had served on the State Medical Board and as president of the American Institute of Homeopathy. Dr. McCann was a Mason and a Baptist. Surviving are his widow, two daughters, two sons and a sister.

Joseph Ray Horatio McDaniel, M.D., East Fultonham; Ohio Medical University, Columbus, 1902; aged 63; member of the Ohio State Medical Association and Fellow of the American Medical Association; died December 14. Dr. McDaniel practiced in Muskingum County and vicinity for nearly 42 years. He had been county coroner and was at one time vice-president of the Muskingum County Academy of Medicine. Active in Republican politics, he was central committeeman for several years. Dr. McDaniel was a member of the Methodist Church and a Mason. His widow and a son survive.

William Henry Mick, M.D., Cleveland; Creigton University School of Medicine, Omaha, Nebr., 1903; aged 66; member of the American Roentgen Ray Society; died December 9. Dr. Mick had practiced in Cleveland since 1927. He served 18 months with the Cornell evacuation hospital unit in France during World War I, and was honorably discharged after the war with the rank of major. Dr. Mick was a member of the Masonic Order and the Episcopal Church. Surviving are his widow and two daughters.

David Henry Morgan, M.D., Akron; University of Wooster, Medical Dept., Cleveland, 1896; aged 78; former member of the Ohio State Medical Association and the American Medical Association; died November 11. Dr. Morgan retired in 1938 because of ill health. He opened an office in Akron in 1902, after having previously practiced in Olivesburg and Smithville. Dr. Morgan represented the Summit County Medical Society several times in the O.S.M.A. House of Delegates. He was a charter member of the Akron Lions Club, member of the Akron Philosophical Society, Celsus Club, Masonic Order and the Delta Upsilon fraternity. A sister survives.

Ewing Dwight Piper, M.D., Shadyside, Starling Medical College, Columbus, 1905; aged 65; former member of the Ohio State Medical Association and the American Medical Association; died November 10. Dr. Piper practiced in Shadyside in recent years. He was previously located in Centerville, Glencoe and Bethesda. Dr. Piper

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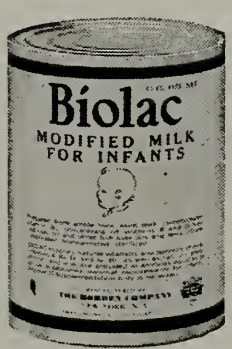
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was a member of the Shadyside Board of Education, the Americus Club and the Presbyterian Church. Surviving are his widow, two daughters, a son, two sisters and a brother.

Ernest Paul Rauch, M.D., Lancaster; Ohio Medical University, Columbus, 1898; aged 66; died November 20. Dr. Rauch practiced in Lancaster for 45 years. A sister survives.

William Peter Reckley, M.D., Youngstown, Eclectic Medical College, Cincinnati, 1928; aged 40; member of the Ohio State Medical Association and the American Medical Association; died November 29. Dr. Reckley practiced in Youngstown for 15 years. He was a member of the Sigma Theta fraternity and the Catholic Church. His widow, his mother, a sister and a brother survive.

Howard C. Sellards, M.D., Portsmouth; Miami Medical College, Cincinnati, 1891; aged 77; former member of the Ohio State Medical Association and the American Medical Association; died November 27. Dr. Sellards first practiced in West Chester, a suburb of Cincinnati, and in 1900 opened an office in Portsmouth where he practiced until his retirement in 1920. He was a member of the Methodist Church. His widow, a daughter, and a son survive.

William Andrew Smith, M.D., Mansfield, Ohio Medical University, Columbus, 1904; aged 62; member of the Ohio State Medical Association; and Fellow of the American Medical Association; died November 23. Dr. Smith practiced in Mansfield for over 25 years. He was previously located in New Dover and Shelby. Surviving are his widow, five daughters, a son, and four brothers, who are physicians: Dr. C. W. Smith, Marlboro, Mass.; Dr. L. A. Smith, Mansfield; Dr. C. E. Smith, Westfield, Mass.; and Dr. H. A. Smith, Worcester, Mass.

John Franklin Spencer, M.D., Norwood; Eclectic Medical College, Cincinnati, 1903; aged 80; died October 29. Dr. Spencer practiced in Detroit until 1920, when he retired because of ill health and located in Norwood. His widow and a son survive.

Josiah S. Steiner, M.D., Bluffton; Cleveland-Pulte Medical College, 1898; aged 71; former member of the Ohio State Medical Association and the American Medical Association; died November 21. The dean of Bluffton physicians, Dr. Steiner had practiced there for 45 years. His widow survives.

Daniel F. Wallenfelsz, M.D., Pleasant City; Starling Medical College, Columbus, 1902; aged 72; member of the Ohio State Medical Association and the American Medical Association; died November 23. Dr. Wallenfelsz practiced in Guernsey County for 41 years. Active in community affairs, he was a member of the Masonic Order and the Methodist Church. His widow survives.

Frank Warner, M.D., Columbus, Bellevue Hospital Medical College, New York, N.Y., 1883; aged 88 member of the Ohio State Medical Association and the American College of Surgeons; died November 28. A native of Ross County, Dr. Warner practiced in Columbus for over 50 years, retiring a few years ago, but still maintaining an active interest in medicine and medical organization. From 1889 to 1908 he was professor of operative and clinical surgury at Starling Medical College. Dr. Warner was intensely interested in civic affairs and charitable activities. He was a member of the State Board of Health from 1898 to 1913, and since 1910 had been a member of the Board of trustees of the Columbus Public Library. Dr. Warner was a member of the Ohio Historical and Archaeological Society and the Optimist Club His widow survives.

John Albert Wilson, M.D., Columbus; Ohio Medical University, Columbus, 1898; aged 76; died December 5. Dr. Wilson had practiced in Columbus for many years. Surviving are his widow, two sons and two sisters.

Wartime Graduate Session Held At Fletcher Hospital, Cambridge

One of the Wartime Graduate Medical Meetings for medical officers sponsored by the American Medical Association, the American College of Surgeons and the American College of Physicians, was held at the Fletcher General Hospital, Cambridge, October 29, with approximately 50 members of the staff and guests in attendance. The serious problem of malaria as it affects the fighting efficiency of Army personnel was discussed in the afternoon by three members on the faculty of the Ohio State University College of Medicine: Dr. Charles A. Doan, chairman, Department of Medicine; Dr. Henry Wilson, Jr., assistant professor of medicine and Dr. Carl E. Venard, parisitologist and medical entomologist.

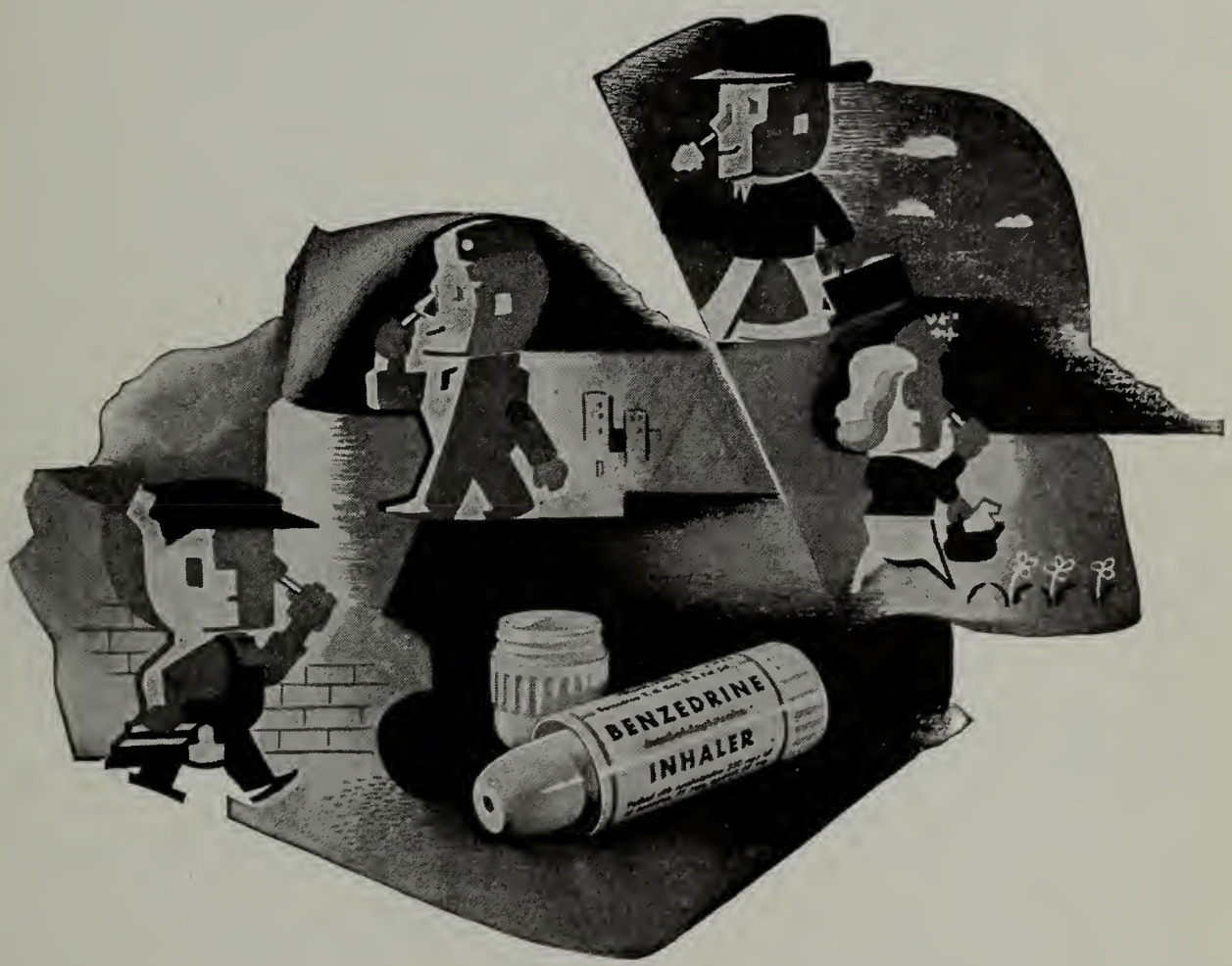
A review of malaria cases at Fletcher General Hospital was presented at the morning session, Major Samuel S. Altshuler, presiding. Greetings were extended by Col. Taylor E. Darby, commanding officer of the hospital. A statistical analysis of clinical and laboratory data was presented by Lt. Col. Mahlon Delp; Major Arthur E. Rappoport and 1st Lt. Franklin J. Mellencamp. The afternoon session was presided over by Major Lewis Pilcher. There were round table discussions and a symposium in the evening, with Major Rappoport presiding.

Columbus—The following are staff officers of the Starling Loving University Hospital for 1944: Dr. Verne A. Dodd, chief; Dr. J. W. Means, assistant chief; Dr. Geo. M. Curtis, chief, surgical division; Dr. C. A. Doan, chief, medical division; Dr. C. R. Baber, secretary.

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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

The Adams County Medical Society has re-elected the following officers for 1944: Dr. R. B. Ellison, Peebles, president; Dr. R. L. Lawwill, Seaman, vice-president; Dr. Hazel L. Sproull, West Union, secretary-treasurer; Dr. R. C. Wenrick, Winchester, delegate; Dr. F. C. Leeds, Winchester, alternate; Dr. S. C. Clark, Cherry Fork, legislative committeeman; Dr. O. T. Sproull and Dr. S. J. Ellison, West Union, and Dr. A. R. Carrigan, Manchester, members of the Board of Censors.—Hazel L. Sproull, M.D., secretary.

BUTLER

Motion pictures of "Continuous Caudal Obstetrical Analgesia" and a demonstration of the Singer Suturing Device were given at a meeting of the Butler County Medical Society, December 9, at Mercy Hospital Nurses' Home, Hamilton.

Officers of the society for 1944 are: Dr. Azel Ames, Jr., president; Dr. Garret J. Boone, vice-president, and Dr. Simon H. Rosen, secretary-treasurer, all of Hamilton.—Mabel E. Gardner, M.D., retiring secretary.

CLERMONT

New officers of the Clermont County Medical Society are: Dr. F. S. Skeen, Batavia, president; Dr. A. B. Ream, Batavia, vice-president; Dr. J. M. Coleman, Loveland, secretary-treasurer; Dr. Allan B. Rapp, Owenville, legislative committeeman and chairman of the Public Relations Committee.—J. M. Coleman, M.D., secretary.

CLINTON

Dr. V. E. Hutchens and Dr. Wm. Kelley Hale reported on the International Postgraduate meeting held recently at Chicago, at a meeting of the Clinton County Medical Society, December 7, at the General Denver Hotel, Wilmington.

Officers of the society for 1944 are the following Wilmington physicians: Dr. Wm. Kelley Hale, president; Dr. R. H. Vance, vice-president; Dr. R. W. DeCrow, secretary-treasurer and chairman of the Legislative Committee; Dr. V. E. Hutchens, chairman, Committee on War Participation, and Dr. DeCrow, chairman, Committee on Industrial Health.—R. W. DeCrow, M.D., secretary.

HAMILTON

At a special meeting of the Academy of Medicine of Cincinnati December 7, "The Facts About

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CHICAGO 12, ILLINOIS

the Wagner-Murray Bill" was the subject discussed by Dr. L. Howard Schriver, President-elect, and Charles S. Nelson, Executive Secretary, of the Ohio State Medical Association.

The following case presentations were made by members of the staff of the Children's Hospital at a Hospital Night meeting of the Academy, December 21. "Cushing's Syndrome"; "Oxycephaly Cranial Morcellation"; "Chronic Ulcerative Colitis"; "Prematurity and Opthalmia Neonatorum (Gonorrheal)"; "Pineal Gland Tumor(?) Precocious Development of the External Genitalia".—Bulletin.

HIGHLAND

Dr. Francis W. Davis, Columbus, spoke on "Ordinary Obstetrics", at a meeting of the Highland County Medical Society, October 18, at the Hotel Parker, Hillsboro.—News clipping.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

The following Springfield physicians are officers of the Clark County Medical Society for 1944: Dr. Wm. P. Ultes, president; Dr. A. A. Gavey, vice-president; Dr. Sterling W. Yinger, secretary; Dr. G. M. Lane, treasurer; Dr. R. R. Richison, chairman, Legislative Committee, Committee on War Participation and Committee on Recreation and Physical Fitness; Dr. C. E. M. Finney, chairman, Committee on Industrial Health; Dr. D. W. Hogue, delegate; Dr. Lane, alternate.—Wm. P. Ultes, M.D., president.

MIAMI

At a meeting of the Miami County Medical Society, December 3, at the Piqua Memorial Hospital, the following officers were elected for the ensuing year: Dr. H. W. Kendell, Covington. president; Dr. J. E. Bausman, Piqua, vice-president; Dr. George A. Woodhouse, Pleasant Hill, secretary-treasurer; Dr. I. C. Kiser, Piqua, legislative committeeman; Dr. J. F. Beachler, Piqua, chairman, Committee on War Participation; Dr. L. N. Lindenberger, Troy, chairman, Committee on Industrial Health; Dr. Harry Wain, Troy, chairman, Committee on Recreation and Physical Fitness; Dr. Woodhouse, delegate; Dr. Russel W. Gardner, Troy, alternate.—G. A. Woodhouse, M.D., secretary.

MONTGOMERY

Dr. D. Guthrie, founder of the Guthrie Clinic, Sayre, Pa., spoke on "Thyroid Diseases" at a meeting of the Montgomery County Medical Society, December 3, at the Dayton Country Club.

Officers of the society for 1944 are the following Dayton physicians: Dr. C. D. Padan, president; Dr. M. D. Place, vice-president; Dr. N. E. Leyda, secretary; Dr. A. D. Cook, treasurer; Dr. R. K. Finley, chairman, Legislative Commitee; Dr. Wallace E. Prugh, chairman, Committee on

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War Participation; Dr. F. G. Barr, chairman, Committee on Industrial Health; Dr. Leyda, chairman, Committee on Recreation and Physical Fitness.—Marie T. Yoder, executive secretary.

Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

HANCOCK

Dr. George M. Curtis, Columbus, discussed "The Nature of Blast Injuries" at a meeting of the Hancock County Medical Society, December 2, at the Elks Club, Findlay.—News clipping.

MERCER

At a meeting of the Mercer County Medical Society, December 14, at Celina, the society went on record as against the principles of the Federal Emergency Maternity and Infant Care Program for wives and children of enlisted men and against the enactment of the Wagner Bill. The secretary was instructed to report this action to the Ohio State Medical Association, U.S. Senators Harold H. Burton and Robert A. Taft, and Congressman Robert F. Jones, Lima. Dr. S. R. Mercer, Ft. Wayne, Indiana, spoke on "Diseases of the Skin".—A. F. Rawers, M.D., Secretary.

SENECA

"X-ray in Pregnancy", was the topic presented by Dr. Alston E. Morrison, Marion, at a meeting of the Seneca County Medical Society, November 12, at the Shawhan Hotel, Tiffin.—News clipping.

Officers of the society for 1944 are: Dr. F. H. Pennell, Fostoria, president; Dr. W. R. Funderburg, Tiffin, vice-president; Dr. G. H. Bruggemann, Fostoria, secretary-treasurer; Dr. John M. Leahy, Tiffin, legislative committeeman; Dr. Robert C. Chamberlain, Tiffin, chairman, Committee on War Participation.—V. L. Magers, M.D., Tiffin, retiring secretary.

WYANDOT

The Wyandot County Medical Society has elected the following officers for 1944: Dr. F. M. Smith, Sycamore, president; Dr. H. B. Wideman, Nevada, vice-president; Dr. R. J. Semons, Carey, secretary-treasurer; Dr. C. W. Montgomery, Sycamore, legislative committeeman; Dr. R. L. Garster, Upper Sandusky, chairman, Committee on War Participation; Dr. S. R. Bame, Carey, chairman, Committee on Industrial Health.—F. M. Kenan, M.D., retiring secretary.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

LUCAS

The Academy of Medicine of Toledo presented the following programs during December:

Dec. 3—General Meeting. "Rheumatic Fever," Dr. H. H. Riecker, associate professor of medicine,

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Dec. 10—Section of Pathology, Experimental Medicine and Bacteriology. Program by Mercy Hospital Staff: "The Newer Concepts of the Etiology and Treatment of Cirrhosis of the Liver"; discussants, Drs. F. C. Clifford, J. B. Rucker, Nelson Morris and G. W. Bascom.

Dec. 17—Medical Section. "Sulfonamide Therapy", motion picture by the Lederle Laboratories.—Bulletin.

PUTNAM

Officers of the Putnam County Medical Society for 1944 are: Dr. H. N. Trumbull, Columbus Grove, president; Dr. J. R. Echelbarger, Ottawa, vice-president; Dr. G. A. Sheppard, Ottawa, secretary-treasurer; Dr. W.B. Recker, Leipsic, chairman, Legislative Committee; Dr. E. Blackburn, Kalida, chairman, Committee on War Participation.—C. H. Zinsmeister, M.D., secretary.

Fifth District

(COUNCILOR: E. P. McNAMEE, M.D., CLEVELAND)

ASHTABULA

Officers of the Ashtabula County Medical Society for 1944 are: Dr. Wm. Millberg, Ashtabula, president; Dr. W. T. Lowry, Jefferson, vice-president; Dr. E. F. Lindenmeyer, Ashtabula, secretary-treasurer; Dr. R. B. Wynkoop, legislative committeeman.—W. T. Lowry, M.D., retiring secretary.

SANDUSKY

Dr. A. A. Brindley, Toledo, Fourth District Councilor, spoke on "The Wagner Bill", and Dr. Leo P. Dolan, Toledo, discussed "Common Urological Problems of the General Practitioner", at a meeting of the Sandusky County Medical Society, December 6, at the Memorial Hospital, Fremont.—News clipping.

CUYAHOGA

The following programs were presented by the Academy of Medicine of Cleveland during December:

Dec. 8—Combined meeting, Industrial Medicine and Orthopedic Section and Internal Medicine Section. "Current Problems in Industrial Hygiene", Dr. J. G. Townsend, chief, Division of Industrial Hygiene, National Institute of Health, Bethesda, Md.

Dec. 10—Joint Meeting, Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine. "Intercapillary Glomerulosclerosis in Relation to Diabetes Mellitus", Dr. T. C. Laipply and Dr. Oliver Eitzen; "Effect of Sodium Citrate on Poisoning by Uranyl Nitrate", G. E. Gustafson, Ph.D., and Dr. S. Koletsky; "Mitotic Rhythm and Growth of Experimental Cancer", Dr. C. M. Blumenfeld; "Studies of the Rh Factor", E. E. Ecker, Ph.D.,



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and Dr. T. C. Laipply; "Reaggin-like Substances in Normal Human Serum", Dr. Herbert Lund; "The Fixation of Complement by Certain Pathogenic Bacteria", E. E. Ecker, Ph.D., and Dr. T. F. Dozois.

Dec. 17—Downtown Academy Meeting. "Some Recent Advances in Chemotherapy with Special Reference to Penicillin", Dr. Chester S. Keefer, Boston, chairman, Committee on Chemotherapeutic and Other Agents of the Division of Medical Sciences, National Research Council.—Bulletin.

GEAUGA

At a meeting of the Geauga County Medical Society, October 27, at Chardon, the following officers were elected for the ensuing year: Dr. A. D. Price, Chardon, president; Dr. W. A. Reed, Burton, vice-president; Dr. Isa Teed Cramton, Burton, secretary-treasurer; Dr. W. C. Cory, Chardon, legislative committeeman; Dr. H. E. Shafer, Middlefield, chairman committee on Industrial Health.—Isa Teed Cramton, M.D., secretary.

LAKE

Probate Judge Pollock made a humorous and instructive address on "Life as Seen in the Probate Court of Lake County", at a meeting of the Lake County Medical Society, December 8, at the Memorial Hospital, Painesville. — E. S. Jones, M.D,. secretary.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

PORTAGE

At a meeting of the Portage County Medical Society, December 2, at Ravenna, the following officers were elected for the ensuing year: Dr. Louis J. Zupp, Ravenna, president; Dr. Myron S. Owen, Ravenna, vice-president; Dr. Emily J. Widdecombe, Kent, secretary-treasurer; Dr. Zupp, delegate; Dr. Owen, alternate.—Emily J. Widdecombe, M.D., secretary.

STARK

The program of the U. S. Children's Bureau for the Maternity and Infant Care of the Wives and Children of Enlisted Men was discussed by Dr. Roy H. Clunk, Massillon, at a meeting of the Stark County Medical Society, November 18, at the Onesto Hotel, Canton. Dr. Blanchard V. Antes, Canton, spoke on "Obstetrical Practices". —News clipping.

SUMMIT

Mr. Frank M. Whiston, Chicago, vice-president, National Association of Building Owners and Managers, spoke on "The Wagner-Murry-Dingell Bill", at a meeting of the Summit County Medical Society, December 7, at the Mayflower Hotel, Akron.—Bulletin.



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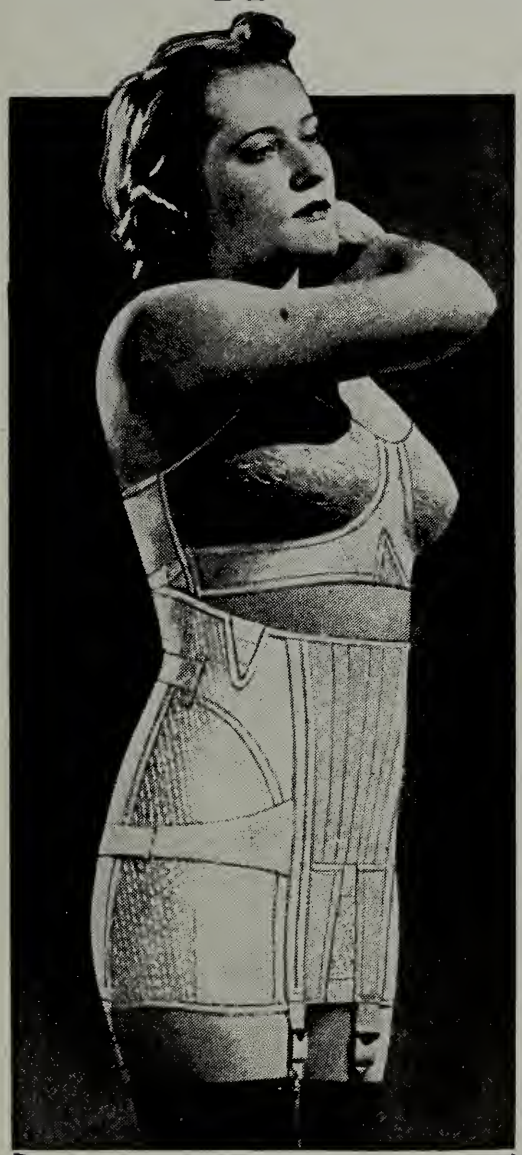
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Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

BELMONT

Members of the Belmont County Medical Society visited the Fletcher General Hospital, Cambridge, December 2.—C. W. Kirkland, M.D., secretary.

TUSCARAWAS

Officers of the Tuscarawas County Medical Society for 1944 are: Dr. D. H. Downey, Dover, president, Dr. John Srail, New Philadelphia, vice-president; Dr. D. M.Ceramella, New Philadelphia, secretary-treasurer; Dr. J. W. Calhoon, Uhrichsville, delegate; Dr. H. B. Kistler, Newcomerstown, alternate.—D. M. Ceramella, M.D., secretary.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

GUERNSEY

Officers of the Guernsey County Medical Society for 1944 are: Dr. Henry L. Wells, Cambridge, president; Dr. J. E. Patton, Cambridge, vice-president; Dr. M. S. Lawrence, Quaker City, secretary-treasurer; Dr. F. W. Lane, Cambridge, legislative committeeman and delegate.—M. S. Lawrence, M.D., secretary.

MORGAN

The following are the officers of the Morgan County Medical Society for 1944: Dr. C. V. Davis, Pennsville, president; Dr. Donald G. Ralston, McConnelsville, vice-president; Dr. C. E. Northrup, McConnelsville, secretary-treasurer, legislative committeeman and delegate; Dr. Ralston, chairman, Committee on War Participation; Dr. Davis, chairman, Committee on Industrial Health. —C. E. Northrup, M.D., secretary.

MUSKINGUM

Dr. R. S. Martin was the speaker at a meeting of the Muskingum County Academy of Medicine, December 8, at the University Club, Zanesville. —Beatrice T. Hagen, M.D., secretary.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

PIKE

Officers of the Pike County Medical Society for 1944 are: Dr. Robert T. Leever, Waverly, president; Dr. I. P. Seiler, Piketon, vice-president; Dr. Mack E. Moore, Piketon, secretary-treasurer; Dr. W. L. McCaleb, Beaver, legislative committeeman; Dr. L. E. Wills, Waverly, chairman, Committees on War Participation, Industrial Health and Recreation and Physical Fitness.—Mack E. Moore, M.D., secretary.

SCIOTO

Motion Pictures on "Anesthesia" were shown at a meeting of the Hempstead Academy of

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Medicine, November 1, at Portsmouth General Hospital.—News clipping.

Officers of the Academy for 1944 are: Dr. C. L. Ferguson, Portmouth, president; Dr. Wells McCann, Minford, vice-president; Dr. Thomas W. Frame, Portsmouth, secretary-treasurer; Dr. J. S. Rardin, Portsmouth, legislative committeeman; Dr. Clyde M. Fitch, Portsmouth, chairman, Committee on War Participation; Dr. R. P. Elder, Portsmouth, chairman, Committee on Industrial Health; Dr. G. R. Micklethwaite, Portsmouth, chairman, Committee on Recreation and Physical Fitness.—George E. Obrist, retiring secretary.

Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

KNOX

The Knox County Medical Society has re-elected the following officers for 1944: Dr. George B. Imhoff, Mt. Vernon, president; Dr. E. V. Ackerman, Fredericktown, vice-president; Dr. F. C. Anderson, Mt. Vernon, secretary-treasurer; Dr. C. D. Conard, Mt. Vernon, legislative committeeman; Dr. J. Shamansky, Mt. Vernon, chairman, Committee on War Participation.—F. C. Anderson M. D., secretary.

FRANKLIN

The Columbus Academy of Medicine presented the following programs during December:

Dec. 6—"Principles of Plastic Surgery as Applied to Injuries of War and Peace", Dr. Claire LeRoy Straith, Detroit.

Dec. 20—Joint meeting with the Woman's Auxiliary. Address of the retiring President, Dr. George T. Harding, and Christmas Party for the wives of members in the service.—Bulletin.

ROSS

Dr. George I. Nelson, Columbus, spoke on "Diabetes" at a meeting of the Ross County Academy of Medicine, at the Town House, Chillicothe, December 2.—News clipping.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

ASHLAND

Dr. Reid P. Joyce gave three case reports on "Adeno Carcinoma of the Bronchus", "Subdural Hematoma", and "Spontaneous Rupture of the Right Auricle", at a meeting of the Ashland County Medical Society, December 10, at the Ashland Country Club. There were 10 members present.—L. Harold Martin, M.D., secretary.

LORAIN

An address entitled "A Critical Consideration of Excretory Urography" was given by Dr. B. H. Nichols, Cleveland, at a meeting of the Lorain County Medical Society, December 14, at the Lorain Country Club.—L. H. Trufant, M.D., secretary.

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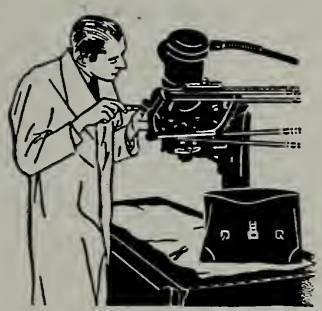
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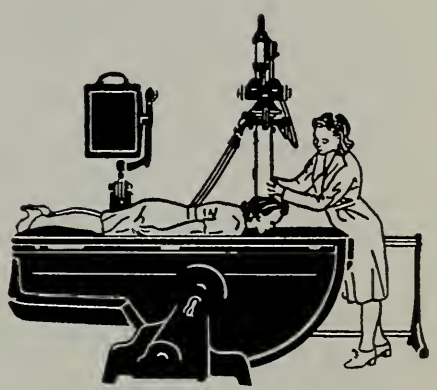
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Woman's Auxiliary News

HAMILTON

During the recent meeting of the Southern Medical Association in Cincinnati, Mrs. J. L. Stevens, Mansfield, President of the Woman's Auxiliary to the Ohio State Medical Association, and Mrs. Eben Carey, Milwaukee, President of the Woman's Auxiliary to the American Medical Association, were guests of the Woman's Auxiliary to the Southern Medical Association. They were also entertained at a luncheon by the Woman's Auxiliary to the Cincinnati Academy of Medicine.

HIGHLAND

On October 18, the Highland County Medical Society entertained at a luncheon at Hillsboro, physicians and their wives from Adams, Clinton and Highland counties. Mrs. J. L. Stevens, Mansfield, president of the Woman's Auxiliary to the Ohio State Medical Association, gave an interesting talk to the ladies following the luncheon.

KNOX

Members of the Woman's Auxiliary to the Knox County Medical Society met at the home of Mrs. James F. Lee, Mt. Vernon, on the evening of November 2. Mrs. Julius Shamansky, Tenth District Director, reported on the Fall Meeting of the Board. Mrs. Ward Jett, the guest speaker, reviewed a current short story.

ROSS

The Woman's Auxiliary to the Ross County Academy of Medicine met at the home of Mrs. Walter C. Breth, Chillicothe, for a covered dish dinner and social session, December 2. Following dinner there as an exchange of Christmas gifts. Thirteen members were present and two guests, Mrs. George I. Nelson, Columbus, and Mrs. Nicholas Holmes.

LUCAS

Under the direction of Mrs. W. W. Beck, the president, members of the Board of the Woman's Auxiliary to the Toledo Academy of Medicine, are campaigninng for new members for the Academy's library.

Named State Psychiatrist

Dr. E. Stanley Anderson, Columbus, was recently named to a newly-created post as state psychiatrist to direct the examination of inmates to the State's four major penal institutions: Ohio Penitentiary, Mansfield Reformatory, London Prison Farm and the Women's Reformatory at Marysville. Dr. Anderson has been psychiatrist at the Ohio Penitentiary since November, 1941, and prior to that time was on the staff of the Longview State Hospital, Cincinnati.

Board's Office Moved

Effective January 1, the address of the Executive Office of the American Board of Ophthalmology will be P. O. Box 1940, Portland, 2, Maine. The Board was formerly located in St. Louis. Officers for 1944 are: Dr. John Green, St. Louis, chairman; Dr. Frederick C. Cordes, San Francisco, vice-chairman; Dr. S. Judd Beach, Portland, Maine, secretary-treasurer; and Dr. Theodore L. Terry, Boston, assistant secretary. The 1944 examinations will be held June 3 and 4 in New York City and October 5, 6, and 7 in Chicago.

Recent Marriages

Recent marriages of Ohio physicians include the following: Miss Lucile Della Tomason and Dr. Robert Jefferson Heaver, both of Youngstown; Miss Lillian Ann Charlillo of Cleveland Heights, and 1st Lt. Arthur F. Millonig of Dayton; Miss Gretchen Ann Hedges of Ashville, and Lt. Robert Sprague Srigley of Columbus; Dr. Laura Kronquist and Dr. Paul Mesaros, Youngstown; Miss Dorothy Irene Tribley, Youngstown, and Dr. Stewart G. Patton, Jr., Canfield.

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Frequently, the Headquarters Office receives inquiries from physicians seeking assistants, partners, or men qualified for positions on private hospital staffs.

If physicians seeking new opportunities or desiring to change locations will file their names with that office, an effort will be made to furnish them with suggestions and at the same time render a service to members seeking assistants, etc.

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The Physician's Bookshelf

Reaction to Injury, by Wiley D. Forbus, M.D. ($9.00. *Williams and Wilkins, Baltimore, Md.)* presents pathology for students of diseases based upon the functional and morphological response of tissue to injurious agents. A beautiful book that deserves the study of most of us. We physicians need a good deal of orientation as to the nature of disease and things of hurt.

A Hundred Years of Medicine, by C. D. Haagensen and Wyndham E. B. Lloyd ($3.75. *Sheridan House, New York City)* is an American text of this English book and is an excellent historical essay. The chapters in the present status of practice will seem redical to most of us. While we do not always agree with the essayists, still we think you ought to read this book.

Textbook of Physiology, by W. D. Zoethout and W. W. Tuttle ($4.75. 8th edition. *C. V. Mosby Company, St. Louis, Mo.)* is a well known text brought up to the minute. Designed for Dental, Pharmacy and Normal School students. It makes an easy text for a review of this field by any physician who has been away for some time.

Introduction to Physiological and Pathological Chemistry, by L. Earle Arnow, M.D. ($3.75. 2nd edition. *C. V. Mosby Company, St. Louis, Mo.)* a shorter text which has been well received. It is an excellent medium for the review of this subject by those of us who have become a bit rusty.

Orthopedic Nursing, by Robert V. Funston, M.D., and Carmelita Calderwood, R. N. ($3.75. *C. V. Mosby Company, St. Louis, Mo.)* brings into one volume the background of medical information and nursing techniques to assist the nurse in caring for the orthopedic patient.

China's Health Problems, by Szemining Sze, General Secretary, Chinese Medical Association ($1.00. *Chinese Medical Assn., P.O. Box 6096, Washington, D.C.)* is the official answer to many questions that we are all asking about a morbidity of 10,000,000 a day; and a mortality of 10,000,000 per year; about private practice, about state medicine; about health education; about medical education; about medical relief, medical supplies. The book deserves wide circulation. Better get a copy for your home library.

Fractures and Dislocations for Practitioners, by Edwin O. Geckeler, M. D. ($4.50. 3rd edition. *The Williams and Wilkins Company, Baltimore, Md.)* stresses the common-sense principles and modern techniques. This book, we predict, will continue to enjoy its success because of the author's insistence upon fundamentals and his gift for simplifying descriptions of complex procedures.

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Vol. 40 February, 1944 No. 2

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.* GEORGE H. SAVILLE, *News Editor*

A Note on Rehabilitation: Work as Therapy

JOSEPH FETTERMAN, MAJOR, M. C., A. U. S.

INTRODUCTION

THE number of soldiers who will have suffered disability from injury and illness is expected to be high. The concentrated fire of modern weapons produces a large number of battle wounds. In addition to war wounds there are the every day injuries from falls, collisions, traffic accidents, not to stress the effects of every day illnesses. The damage wrought by blast and bullet and shrapnel obviously leads to scars in the injured tissues and deformities of the body. Disorders of the nervous system, as well as direct involvement of muscles and joints lead to weakness, stiffness, and paralysis.

Such disabilities involving civilian and soldier are accompanied by the additional symptoms contributed by the mental attitude. Injury brings with it fright, anxiety, and sets in motion mental attitudes some of which are unhealthy. Such mental processes may engraft an overwhelming disability upon a simple structural defect. It is not rare to see a patient who has suffered a slight fracture develop a secondary paralysis upon a hysterical basis.

We may expect war to bring an added number of disabilities among soldiers and civilians as a result of combat wounds, every day injuries and illnesses. We should prepare to anticipate this problem with measures which will convert such patients into useful, even though handicapped individuals. (Cairns,[1] Jefferson, Brain[2]).

The chief methods available have been medical and surgical.[3] Surgery can accomplish much toward improving muscle power, removing disfiguring and stiffening scars; drugs can correct faulty physiological processes, relieve pain, reduce muscle spasticity, and calm tension; physiotherapy will contribute towards muscle freedom as well as train muscle function. Psychotherapy occurring from these measures as well as given directly will do much towards the removal of emotional obstacles to recovery and may stimulate the will to get well. Thus rehabilitation is achieved by several interrelated procedures: the improvement in local function, the trained skill, general well being, and the willingness to work. But there is needed the opportunity to untilize the improved functions—an available job. A discussion of work as an aid to therapy is the purpose of this paper.

From the School of Military Neuropsychiatry, Lawson General Hospital, Atlanta, Georgia.

The Author

● Dr. Fetterman, Cleveland, Ohio, is a graduate of Western Reserve University, 1921; diplomate, American Board of Neurology and Psychiatry; assistant physician (neurology) Lakeside Hospital; assistant clinical professor, Nervous and Mental Diseases, Western Reserve University School of Medicine.

THE IMPORTANCE OF WORK IN REDUCING DISABILITY

One of the most impressive recent articles dealing with the recovery of patients who have suffered from injury is a report by Guttman,[4] of London. This article points out the relatively prompt recovery of civilians who had sustained head injuries and who were treated with short periods of rest in bed and brief hospitalization. The speed of recovery was prompt and the prognosis appeared favorable. One is left with the

inference that this brief period in bed and psychotherapy were responsble for achieving such quick results. Not enough credit was given to the prevailing atmosphere and to the work situation in London. During peacetime an injured person received a good deal of attention and sympathy and may have delayed his return to work. Perhaps his job was disliked, or when he recovered there was no work to do. Today the situation is changed completely. Neither the public nor the profession has the time nor the patience for an extended number of sick calls, nor can much sympathy be spent upon a civilian with some minor injury when every Londoner has a son now involved in hazardous war duties, or perhaps already seriously wounded and in an army hospital. Such is the spirited drive for victory that the public disapproves of illness and idleness, and applauds him who despite some handicap is contributing his share and more to the war effort. Soldiers in the front line can not leave their post even if troubled by a few symptoms. Above all, the convalescent Londoner knows that a job is waiting for him, a job with good pay, a job in which he can forge weapons to destroy the enemy. Work thus becomes an incentive towards recovery. Consequently an injured person is apt to return to activity though troubled by a few residual symptoms. Slater[5] has convincingly shown that a pleasant work situation as that which prevails in the Eastman Kodak Company reduces the tendency toward neurotic illness. His observations demonstrate that interest in work and adequate rewards will direct thoughts away from symptoms and to effort.

During the past few years there was established in Cleveland a protected workshop for hitherto unemployable epileptics. This project, named "The Auracraft Shop" (Fetterman and Greve)[6] has provided training and work experience to previously idle and, for the most part, unhappy sufferers from epilepsy. The change in outlook and the lessening of symptoms as well as the improvement in personality were striking. Work, especially a pleasant occupation, is a tremendous factor for recovery.

PSYCHOLOGICAL FACTORS IN THE WORK SITUATION

We all are aware of the fact that work removes worry. How does this come about and what are some of the factors in the work situation which are helpful in reducing disability?

Work involves not alone muscular effort, and its influence extends beyond the material gains. There is the element of socialization. There is the relationship to fellow employees and to superiors; there is pride in learning and advancing, and in many instances the satisfaction of a job well done. Yet, we must recognize that a job poorly rewarded and work under hazardous conditions in an atmosphere of stress and strain, and particularly labor of a monotonous nature, create unhappiness, irritability, and dissatisfaction.

Let us consider certain individual items in the work situation.

(a) The material reward.

If certain features are the poetry of work, the material aspect is its prose. To cope with problems of nature, work is necessary for life. The farmer must till his soil and raise his crops or else face starvation. The miner must dig coal, the tailor sew garments to provide warmth, houses must be built, fuel furnished and food prepared so that man may survive. Life is maintained through painful muscles, toil and sweat. Yet there is a feeling of satisfaction when man has performed his duty and satisfied his needs.

(b) The social aspects of work.

Most jobs involve teamwork and supply man with one of his most important needs—contact with fellowmen. We must share our joys, we need sympathy during periods of sorrow, there must be some rivalry and competition, there is even an instinctive tendency to show our superiority by claim or performance. Work involves not only such relationships, but the problem of employee and chief, instincts of loyalty, the need for approval and advancement, are all expressed in the work situation. Thus we find that many a person is happier when busy with his fellow workmen than when alone with himself. Of course it is a tragedy all too frequent when a workman receives few rewards and little recognition, and when he is the butt of jokes and pranks, and the victim of the condemnation and superiority feelings of others. Under such circumstances the job is no incentive. It is a painul ordeal to be endured because of necessity and from which the person will remain away as long as possible when sickness and injury affords the opportunity for honorable and compensated escape.

While working and during the rest periods the employee has a feeling of communal spirit, a sense of belonging to the organization. He participates in discussions, he exchanges views. There is a sense of refreshment in being away from home. The housewife who allows the dinner to burn while she is discussing events and personalities over the back door fence demonstrates the importance of the social needs of people.

(c) The interest in work.

Our jobs and the products we create are an extension of our personalities. They represent the expression of our dreams, the concrete fulfillment of our manual dexterity and our imaginations. They afford us with the opportunity to create, to impress, to achieve. Think for a moment of the writer working on his novel, the sculptor modeling a statue, the master craftsman building his

machine. Picture the planning, the labor of love, the anticipation of success, the joy in the work well done.

It would be ideal if all work were creative, safe, and interesting. Most jobs fall far short of this ideal. When the work is unsafe and dangers abound, when the daily routine is monotonous, then there is little stimulus for personality development. Even in such instances the pride in the product of the whole organization, the effort to improve or to better the record, may supply some incentive.

On the positive side, work furnishes substance, socialization, and an interest in the product. There is often the sense of well-being which comes with muscular activity. Furthermore, work absorbs our thoughts and draws them away from introspection or unhappy reflection.

WORK AS A MEANS OF REHABILITATION

The recent literature is taking note of rehabilitation. Yet this is no new idea, nor is it the function of any special group. A recent editorial in the *British Medical Journal*[7] impresses upon every physician that it is his duty to see the patient through the illness until he is economically useful. It indicates, therefore, that rehabilitation is a concern of the physician and is part of the doctor's treatment program often relegated to some affiliate group such as physiotherapy or social service.

We may now touch upon several general principles of work as a means of rehabilitation.

(a) Productivity of the handicapped.

Not all work is done by those who are perfectly well and sound. A handicap need not erase one's ambition nor destroy one's usefulness. The world's history is rich with examples of those who have been successful in spite of or possibly inspired by some handicap or defect. The will to achieve may inspire us to greater effort, to over-compensate for the defect or the handicap, to redirect our energies towards other goals. Spinoza, restricted by shyness and poor muscles to a sedentary life, directed his thoughts to a better appreciation of philosophy. Helen Keller, minus hearing and vision, nevertheless rose to a useful career. Our President, despite a paralyzed leg, has achieved national and now international distinction as a leader. In every city are successful people who have achieved success despite some crippled state of limb. Hubble[8] described the physical condition of Darwin and makes the suggestion that Darwin's greatness was related to the handicap of repeated nervous maladies. According to Hubble, normality for Darwin might have meant a sacrificing of his genius. Minski[9] lists Michael Angelo, Beethoven, Shelley, Brahms among cripples who attained fame.

Every handicapped person possesses some faculties which are capable of use. Our aim must be directed towards the encouragement of the abilities, not towards the emphasis of the disabilities of the handicapped.

(b) Limitation of physiotherapy.

Rehabilitation was first sponsored by orthopedic surgeons, and physiotherapists associated with them. The earlier efforts were in the direction of muscle training and work education suitable for those who are handicapped. This was a positive and useful step. Muscle re-education for those with weak, stiff, and impaired muscle function is valuable. Yet it is sometimes forgotten that muscles are but the messengers of the mind. Physiotherapy is valuable not so much to the degree that it influences single muscles but to the degree to which the mental attitude is modified towards effort. What is done by accessory muscles is more important than the local improvement of the injured or paralyzed group of muscles. We admire the benefits of surgery and of the physiotherapy methods which follow surgical procedures. We must not lose sight of the fact that the usefulness of the injured man is more directly connected with his mental attitude than with muscle status. As has been recounted in "The Mind of the Injured Man", a neurotic patient may be given months of physiotherapy without avail because the emotional processes of this patient were opposed to work. Physiotherapy is valuable when coupled with or as an avenue to psychotherapy.

(c) Work as a stimulus to recovery.

Sometimes recovery is delayed by the previous work situation or by other factors which remove the incentive of work. A job which provides an adequate reward, socialization, interest and pride in the product serves as a tremendous incentive to effort. This incentive causes the patient to relegate his symptoms into the background. On the other hand, an unpleasant job or inducements to illness such as too much sympathy or too much weekly compensation will bring the symptoms into the foreground.

There are certain men hurt at work who go through an extended period of disability. A thorough examination shows little or no physical disability to account for such delayed convalescence. Study reveals a fear of the hazards involved and a dread of recurrence of the injury, or an intense dislike for the personnel, hostility towards the employer. The disability then serves as an escape or becomes a revenge mechanism, which is used against the employer. In such instances, a change of jobs facilitates recovery.

When the task is pleasant, interest is extraverted. The workman becomes concerned about his craft, not his complaints. All of us forget our minor aches and pains when our tasks absorb

us. And this incentive encourages us subconsciously to utilize muscles and resources which may have been dormant.

(d) Removal of the obstacles to work.

There are incentives to sickness as there are to work. The wish to enjoy a long vacation is almost universal. The wish to fall ill—or the tendency to cling tenaciously to symptoms, is present in psychoneuroses. Such a tendency can be influenced by material and psychological factors. Weekly or monthly compensation checks for the duration of disability maintains interest in symptoms. Such a check is proof of suffering; it provides some material needs, it is revenge against the employer who has to pay it. Furthermore, some persons fear to give up the certainty of a monthly check for the uncertainty of the job. Either the job is seasonal or the employee fears he may be discharged soon after resuming work. Veterans receiving monthly pensions show a poor recovery rate. (Aring and Bateman).[10] Thus, for work to serve as a force to recovery, we should not reward idleness financially after a certain point.

The psychological obstacles to work usually occur prominently in the psychoneuroses and in the psychopathic personalities. Subconsciously they gain more from illness and idleness than from work. The psychopath uses illness and its material compensation as a justified cause for an inner tendency to avoid work and responsibility (Porter).[11]

PRACTICAL STEPS IN THE UTILIZATION OF WORK AS A THERAPEUTIC AGENT

As a supplement to the medical and surgical procedures, we should utilize work as a means of reducing the period of disability and of accelerating recovery. This is a simple matter or no problem at all when one is his own employer. As a rule he resumes activity gradually, doing a little at first and more each day in accordance with his returning capacities. He is not fearful of being fired; nor does he hesitate to rest more if necessary. On the other hand, a person employed in industry faces many problems between illness and a return to work with a handicap. First is the employee's hesitancy to relinquish compensation; then comes his fear of hazard; the dislike of the job and fear of being discharged. Industry hesitates to employ a disabled man because it is felt he can not be relied upon, as another mishap might convert him into a permanent invalid at a great cost to the company, and finally because jobs suitable for handicapped may not be available. What can be done to minimize these obstacles to re-employment? The high percentage of employment of handicapped persons during war time shows clearly that these obstacles can be set aside or overcome. The following suggestions are offered:

(a) Do not reward illness of a psychoneurotic nature long beyond the time when the organic phase has healed. True, a psychoneurosis is a form of illness, but it should not be reinforced by payment. By no means should weekly or monthly routine payments be given for duration of symptoms. A lump sum settlement is advisable. The convalescing patient should not be encouraged to prolong his illness by excessive sympathy or by prolonged compensation.

(b) Work should offer an incentive.

It should be the aim of all employers to provide features above compensation that make the job an inducement. Many jobs are of necessity unpleasant, disagreeable, dangerous, and distasteful. Yet the financial return; the possibility of promotion; sickness and old age pensions; possibly a share in the business, however small, may serve as inducement. The welfare of workers is good business as well as good medicine.

(c) Lessen hazards at work.

Some jobs are unavoidably dangerous. Yet many of the risks can be reduced by adequate safety measures. Chemical firms have taken steps to cut down the hazards from industrial poisons by proper ventilation and the use of masks where indicated. Safety engineers can provide appropriate methods to reduce industrial accidents. This will serve as an inducement to return to work.

(d) The transition period should be flexible and individualized to the progress of the convalescent employee. Following most injuries there is a gradual day by day change toward increased function. One should not wait until 100 per cent recovery is attained for this may mean an extended delay. Between complete disability and full recovery there is a transition period of partial usefulness. We should encourage employees to return to part time employment, with the assurance that they would not be criticized if they should pause or rest or leave early. A period of trial work should be provided—and fostered by giving the employee good pay. Likewise, I have encouraged insurance companies to continue payments during this period so as to remove any fear that such a person might have of losing his indemnity and also be unable to work. As a rule, employees who start to work continue at it.

No employee should be discharged during this transition period. This fear of being fired is prevalent among workmen and must be based upon experience. However trying an employee might be, to discharge him during this transition period is to discourage others from an earlier resumption of work.

(e) Placement of handicapped.

As has been amply demonstrated during the present war, industry can make a place for the

handicapped, and the handicapped can be useful. The reasons for the indifference to them in the past arose from:

(1) The availability of able-bodied men, and (2) concern about increasing insurance premiums because of recurrence of disability.

Following the war, some of our finest men and women may have some disability. It is the able-bodied young and intelligent man who is the soldier. There remain in industry a small number of vitally essential persons, the aged, and those excluded from the army because of some defect. Hence, in the future, the veteran, even though he has some disability, may prove to be more useful than the man left behind.

Furthermore, it will be the duty of our nation to provide a happier life for him who has sacrificed for its welfare. Preference or justice must be shown to these men, even though handicapped. Our duty to them must take preference over our desire for profits. It should be the patriotic policy of all industry to offer employment to veterans even though they show a handicap.

The matter of insurance responsibility should be met by a waiver system through which a disabled employee does not place the burden upon an employer who is in no way responsible for his difficulty. The details of such waiver should be worked out by casualty experts and state insurance funds. This need is ably described by Johnstone.[12]

"Too long has industry cast aside those with slight physical defects. A wasteful nation has heretofore piled high a scrap heap of materials and men. For the war we have reclaimed wasted rubber, tin, and iron. For the peace we must salvage man power. For war production management has been forced to accept the physically handicapped or the elderly workman. To utilize these, selection of the job to suit the applicant has been practiced, a prophetic policy when analyzed. It signifies the post-war adoption of placement examinations.

"However, before industry can be asked to accept the war-wounded or the physically-handicapped, a legal determent found in the Workmen's Compensation Act must be removed."

(f) Vocational guides.

Every large government hospital should have vocational experts who can advise employees where to find suitable employment. Such experts familiar with industry and with the many different specialities and types of work should be a clearing station between supply and demand. They should keep a list of possible jobs and of men seeking them. A good job at the right time has cured many a disabled person. Proper placement has been the function of psychiatrists employed by some large concerns. (Anderson of R. H. Macy & Co.) Vocational guidance for disabled veterans will be provided by the Rehabilitation Service (Kratz).[13]

(g) Vocational training.

Certain handicaps utterly disqualify a person to perform the work for which he has been trained. A window cleaner with a stiff leg can no longer climb ladders and must learn some job with his hands. We should teach and train certain disabled persons to use those limbs and muscles which are intact. Such training should be available only if a person eagerly seeks help and exhibits a will to work. Too often I[14] have seen courses of training being given to injured employees who made no use of them whatsoever. H. J. injured his hand in a machine shop. He remained disabled for many years because of a complaint of pain; largely due to a psychoneurosis. He was referred for vocational re-education and was given a course as an upholsterer. He completed the course but continued to complain of pain, weakness and nervousness, and he suggested that he would like to learn to be a radio operator. This was but an excuse—his will to work was submerged by a neurotic preoccupation with somatic complaints. Train men, therefore, only when they have shown a will to work.

COMMENT

The importance of work as a factor towards recovery may be illustrated by my experience with patients referred by the Industrial Commission of Ohio. During the depression years from 1933 to 1937 the insecurity from probable unemployment was a bar to recovery. However, in 1938 to 1941 and especially when we engaged in war the availability of a job accelerated recovery. The significance of work as a therapeutic factor may be seen from the case history of L.M. who had injured his back as a truck driver. X-rays showed a linear fracture of a transverse process. He was confined to a hospital and a cast applied. But for many months after the injury his disability continued. Despite massage and heat he remained an invalid. When his case was studied I learned that fear of paralysis had maintained his disability because he had been informed that his back was broken and so for several years he had guarded all movements, was ever watchful and fearful lest a sudden shift cause him to become paralyzed. A clear explanation helped him considerably, but no definite improvement resulted. Finally the recovery was achieved when a former employer offered him a worthwhile job.

The soldiers who will return from combat handicapped as a result of injury may be guided along one of two roads. First is the path of pity, prolonged stay in a convalescent hospital, pension, and usually inactivity. The other is up-

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hill, giving up attention and foregoing monthly compensation, and making the effort to be useful and self-sustaining. Encouragement and training will help—provided there is the goal of a job ahead.

Some men possess the initiative to find a niche; the majority will need vocational guidance and vocational opportunity. Who is concerned with the welfare of the injured soldier must therefore plan not hospitals and pensions but work and pay. So vast are American industries and so variable the different skills and procedures that places could be found for practically every man who has the will to work. Desk jobs should be made available for those whose legs are crippled or amputated, farming, gardening, landscaping and such careers would afford head injury cases a chance to be usefully employed. Recently someone suggested the various duties on a golf course as an opportunity for certain disabled veterans. These types of jobs are almost limitless if we realize the importance of them.

CONCLUSION

Rehabilitation can be achieved through many avenues—or rather is the product of several forces. Chief of these is the effect of medicine and surgery to correct defect and improve function, and to inspire the will to get well. As a supplement to these forces we must include the social and economic influences, particularly work.

Work provides activity, socialization, and interest, and tends to reduce worry and preoccupation with symptoms. Work may be an obstacle or an incentive to recovery. An available job may induce and accelerate improvement. Work should be an inducement to those convalescing and also should provide an outlet for the handicapped to use their intact talents. We must utilize the capacities not emphasize the defects of our handicaps.

Society must plan to employ more handicapped in industry. Vocational training, guides to jobs, and the employment situation must be provided to utilize the capacities of the handicapped.

I wish to express my thanks to Colonel W. C. Porter for helpful suggestions.

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Infant Feeding and Vitamins

It is an interesting fact that anorexia is an almost nonexistent complaint in negro children, and it is not an unreasonable assumption that this may be attributed to breast feeding in the early months, supplemented by home-cooked foods in the latter months of infancy. Infants whose parents find themselves within low economic brackets are less likely to be the victims of the advertisement pressures which guide their more enlightened and more prosperous neighbors into less satisfactory diet programs, for after all, the infant who is fed on breast milk or on fresh cow's milk, with the addition of some home-cooked fruit and vegetables in the later months of infancy, is getting a diet which amply provides not only the nutritional cornerstones of protein, fat, and carbohydrate but, as well, the vitamin bridgehead which will carry him safely over into the mixed-feeding period of early childhood.

Vitamins have a place, and a very essential one, in the nutritional program, but their fulsome exploitation in clever and specious advertising campaigns has caused, and is continuing to cause, a great waste of this valuable food factor in their injudicious and often unnecessary administration. We should debunk the vitamin racket.

Breast-fed babies and those on satisfactory artificial formulas should have their diets fortified by adequate amounts of vitamins C and D beginning at the second month. Between the fifth and sixth months the addition of cooked cereals and home-cooked fresh vegetables will insure an adequate vitamin addition to the diet, and it should not be necessary, save in exceptional cases where vitamin inadequacies are definitely and clinically demonstrated, to add additional vitamin preparations to the diet.

Conservation of child health and life represents perhaps the most important contribution which we can make to the nation at war. We can do this best by cooperating with nature in her directives of emphasizing the importance of breast feeding to its physiologic optimum, and of adding to the infant dietary regimen of the adequate and essential food factors—protein, fat, carbohydrates, minerals, and vitamins—without any drain on the family's allotment of red or blue ration points.—Norman M. Macneill, M.D., Philadelphia; Penn. Med. Jour., Vol. 47, No. 3, Dec., 1943.

The Doctor's Heart

J. H. MUSSER, M.D.

CORONARY arterial disease has been referred to many times as the doctor's disease. The pathologic changes produced in the heart by sclerosis of the coronary vessels are responsible for the doctor's heart. That this term is not a misnomer can be substantiated by the vital statistics reports of the last few years. In 1942, for example, there were 3,329 deaths of doctors listed in *The Journal of the American Medical Association.* The causes of these deaths have been broken down in an editorial which appeared in the *J.A.M.A.* January 16, 1942. Heart disease was responsible by far for the greatest number of deaths amongst doctors. Of those physicians who died, death in 627 instances was reported as coronary thrombosis and occlusion with other coronary diseases, and angina pectoris listed to the number of 143. Eight hundred and thirty-eight deaths were the result of "disease of the heart and myocardium". There were listed also a considerable number of deaths as result of arteriosclerosis and its end results. Presumably a goodly number of these patients had coronary arterial disease as some of the diagnoses are quite inexact, indefinite and inconclusive, being reported merely as cardiovascular renal disease to the number of 217.

Categorically there were listed then 770 deaths as result of coronary disease and presumably of the 838 physicians who died as result of other diseases of the heart and myocardium, sclerotic coronaries were responsible for the myocardial pathology in a large percentage of instances. After all, when the diagnosis is made of myocarditis, presumably it may be pathologically correct but the pathogenesis of the myocarditis in most instances is insufficient blood supply to the myocardium which in turn is dependent upon pathologic changes in the coronary vascular system. Certainly most of these deaths will not be attributed to the other two great causes of heart disease, namely syphilitic and rheumatic heart disease. It is the exceptional doctor who dies as result of syphilitic heart disease; he knows too much about lues and is too keenly aware of the end results of syphilis to forego proper treatment. Only the occasional physician dies of rheumatic heart disease because by the time a man has become a doctor he has passed the usual period of life in which rheumatism may develop. Most persons with rheumatic heart disease develop it in youth and are not able to stand physical rigors of obtaining a medical education.

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As to other etiologic types of heart disease, certainly very few doctors die from a thyroid heart. Here again the physician is able to recognize his symptoms, obtain treatment before the thyrotoxicosis has caused heart damage to a considerable degree. * * * *

The statements above are presented to substantiate the idea that coronary arterial disease is responsible for a large number of deaths in doctors and that many of the diagnoses that are not put down as coronary affections are also due to coronary disease. In other words, about one-third of the deaths of physicians in this country are due to the late effects of sclerosis of the coronary system. These deaths exceed by an enormous percentage deaths from any other cause. Cancer, which in vital statistics, ranks second as cause of death in this country, brought about the demise of only 181 doctors in 1942. Respiratory diseases caused the death of 239 physicians, 22 of whom died of lobar pneumonia. Under the very vague term of diseases of the gastrointes tinal tract there were 139 deaths and 123 doctors died as result of accidents. It can be seen then that there were only a few causes of death which exceed 100 in number, whereas coronary disease was responsible for over 1,000 deaths of members of our profession.

HISTORY

When one considers the figures that have just been given in regard to frequency of coronary disease among physicians, it is truly remarkable that this disease had never been recognized as a clinical entity until a short time ago. As a matter of fact it was not until World War I that the medical profession began to appreciate the importance of Herrick's observations first made in 1912, in a paper which raised practically no comment, discussion or outstanding interest. As a mattter of fact Herrick speaks of this paper as being dud. The second paper was a big bomb which went off with tremendously devastating effects. In a short time physicians became coronary artery conscious and a series of excellent papers by such men as Libman, White, Levine, Pardee, Wolferth and others substantiated Herrick's thesis and added additional clinical obser-

vations as well as pathologic and electrocardiographic information about the disease which has resulted in a clear-cut, readily-diagnosed syndrome about which there is little that is not known.

ETIOLOGY

The primary etiology, of course, is arteriosclerosis. Sudden obstruction of a normal coronary vessel may occur as result of embolism but it is extremely rare. More frequent indeed is the gradual obstruction which is the result of arteriosclerosis and which suddenly, in most instances, closes up as a result of intravascular thrombosis. It is one of the most common causes of sudden death.

Why occlusion takes place in the coronary vessels frequently, and rarely elsewhere, and why the coronary vessels of the body are the site of highly developed sclerotic changes when the other vessels of the body show but little change, are moot points. It is probable the coronary vessel which biologically is one of the oldest arteries in the body may be the subject of certain developmental faults which throw a greater strain upon it than does the ordinary blood vessel suffer elsewhere.

The diabetic is prone to have arteriosclerosis and is also prone to have coronary occlusion which is one of the most important etiologic conditions predisposing to the disease. Hypertension is another antecedent disorder which is usually always stressed but I will remind you coronary occlusion occurs frequently in people who do not have elevation of blood pressure. I could recount instance after instance of people who have had regular physical examination, at which time the blood pressure was normal, who have died a sudden cardiac death.

Heredity is of extreme importance as an etiologic factor. Just as there are families who are hypertensive families and whose members die at a young age, just so are there families in whom coronary disease is remarkably prevalent. I know of one doctor's family tree in which 10 or 11 of the doctors died a sudden heart death which undoubtedly was the result of coronary disease.

Men are more frequently attacked than women. There are all kinds of figures to bear out this statement, some of which give only a slightly higher percentage in the male than female, others in which there is a marked predilection for the male sex. Personally I rarely see a woman with coronary occlusion, but frequently men.

PATHOLOGY

The occlusion may take place without the production of an area of infarction. This occurs in the gradual and slow occluding processes which are not particularly dramatic in their expressions. On the other hand, in the patients who have clear-cut symptoms which are highly characteristic there is usually infarction present. But this infarction is never as great as one would anticipate from the size of the vessel that is occluded and which supplies a goodly part of the blood to that area of the heart. This is dependent upon the fact that there is extensive anastomosis between the right and left coronary vessel and these anastomoses in the left ventricle at least produce collateral circulation which is more pronouncedly widespread in the older individual than in the younger.

Blood will be supplied to the infarcted area and healing may take place because a new source of blood supply will be evolved and the existing mechanism for delivering blood to the heart will be augmented. The Thebesian vessels will supply a greater amount of blood to the heart. Anastomoses I have just mentioned. Extracardiac anastomoses may be present and the blood may be forced into the coronary vessel itself up to the area of occlusion by the to and fro pumping action of the heart.

SYMPTOMATOLOGY

The story of coronary occlusion is in most instances typical. The severe substernal pain occurs frequently without any initiating factors, as the occlusion which occurs at night time when the patient is in bed. The pain is persistent, does not disappear promptly with nitroglycerine but lasts from six to 36 hours, and gradually subsides after the initial severity. On the other hand, there are dubious cases in which the pain may be more or less transitory or even non-existent. The pain, instead of being referred down the left arm, may be referred to the right shoulder and arm. The epigastrium may be the site of the pain so that when associated with vomiting a series of symptoms is produced which are often mislabeled acute indigestion, acute gastritis or acute cholecystitis. In patients who have no pain there does occur severe shortness of breath which is apparently causeless. Irrespective of whether or not pain is present a patient usually shows the customary expressions of shock. Of course in those patients who have associated severe pain, these shock symptoms are often predominant and outstanding. To be cautioned against is what I may speak of as deceiving drop in blood pressure. The patient has the symptoms of shock and the blood pressure is found to be 138/85, figures which are not at shock levels. It is advisable for the doctor, if he does not know the patient, to inquire of him what were the previous blood pressure readings. In most instances he will find these are hypertensive people who have had drop in blood pressure of 50 to 70 mm. mercury.

Dyspnea is a symptom which must not be neglected. The sudden occurrence of shortness of breath without pulmonary edema and without any

attributable cause may be the chief manifestation of coronary occlusion. The symptoms of heart failure may occur promptly but congestive failure is not of immediate moment but more likely to occur days after the initial onslaught.

PHYSICAL SIGNS

The immediate physical signs are those of a heart that is working under stress. Gallop rhythm may be heard, the apical impulse may be indefinable and the heart sounds may be weak. In about 40 per cent of instances irregularities will occur, usually ectopics but once in a while the heart rate falls to a very low figure as a result of the area of infarction extending to the bundle of His and producing heart block. The very rapid heart rate, ventricular tachycardia, is a cause for worry. Ventricular tachycardia may precede the ventricular fibrillation which causes the patient to die. Forty-eight to 72 hours after the initial blow, the signs of relative insufficiency, such as systolic mitral murmur, may be heard. This likewise is the time that the friction rub may be noted. It is often very evanescent; it may come and go; it may come, last for only a short time, a few hours, and never reappear. If there is posterior wall infarction it will not be heard and only noted when there is considerable area of infraction as result of occlusive thrombosis of the anterior descending branch of the coronary artery. Fever is noted and the usual physical signs that are associated with fever will be observed.

LABORATORY EXAMINATIONS

Leukocytosis is present and is in direct relationship to the size of the infarct. The same statement applies to the elevation of temperature that occurs six to 48 hours after the onset. The electrocardiogram is of great diagnostic value. Serial changes take place in the electrocardiogram which are of great moment. Early in the course of the disease the most characteristic finding is high take-off of the T wave and widening of the QRS interval. The T wave undergoes progressive changes and ultimately becomes isoelectric and finally negative.

THE AFTER EVENTS

The patient may die very promptly as result of shock, ventricular fibrillation or even, but rarely, heart failure. Death occurring a few days after the initial attack is likely to be the result of heart failure, emboli, heart block or even rupture. Patients may improve for a time and then begin to develop the signs of heart failure which may cause their death, within a few months. About 30 per cent of patients will die in the first attack. I do not think that the figures that have to do with survival of the patient are accurate. Many a patient has a small area of infarction which is undiagnosed and probably the figures of the first attack causing death and the survival figures would be considerably modified if we were sure that the first and second attacks were always recognized. It is my belief that coronary occlusion and infarction are not as lethal as generally considered.

A certain group of patients who survived will eventually develop heart failure.

TREATMENT

Immediate treatment, of course, is complete physical and mental rest. The patient should be given a large dose of morphine sufficient to control the pain. Papaverine is coming into favor because it does not have the vasoconstricting effect that morphine does, working through the vagus. Unfortunately papaverine is not in my experience sufficiently powerful to relieve pain in many instances, so morphine must be used but as soon as possible switch to papaverine and replace the more powerful morphine. Shock is treated by the usual methods, principally rest plus the slow introduction of five per cent glucose into the vein. When stimulants are needed caffeine sodium benzoate in doses of one-half gram hypodermically is probably the best stimulant.

The after care of the patient is of importance. The usual procedure is to keep the patient absolutely quiet for three weeks and then let him start to do very light exercise such as going to the toilet but if the fever has been high and the area of infarction seems to be quite extensive, more physical work than movement to the bathroom should be restricted for an additional three weeks. Fairly complete physical rest is indicated for at least six months. This is a controversial point because there are some cardiologists who maintain that the circulation to the heart is vastly improved by physical work, modified of course and considerably restricted. This is a rational point of view but I must confess that I would be timid rather than bold and would prefer to follow the long rest regimen which has been used widely and generally.

In patients who have had a recognized attack of coronary disease I believe it is advisable to give aminophyllin more or less continuously for months or even years. This is on the basis that these xanthine preparatons are capable of increasing coronary circulation. Aminophyllin is sometimes disturbing to the stomach, therefore theocalcin may be used as a substitute although it is probably sometimes less effective than aminophyllin in increasing coronary blood flow. In patients who are nervous and high strung theominal may be given or if it is considered preferable to give phenobarbital by itself this may be done.

A Method For The Repair of Finger Amputation

WILLIAM KUTLER, M.D., Cleveland, Ohio

DURING this critical period when industry is employing thousands of women and inexperienced men on machines, there has been a great increase in the incidence of crushed finger tips. When the greater part of the terminal phalanx together with the nail matrix is crushed the usual type amputation just above the joint with a ventral flap is satisfactory.

It is the injury in which about one-half or two-thirds of the terminal phalanx is crushed or punched off and in which the nail matrix is practically intact that the method described is particularly applicable. In these cases the procedure usually employed is one of the following:

1. Smooth the end of the phalanx and allow the tip of the finger to granulate in.

2. Full thickness on pedicle grafts to cover the crushed end of the finger.

3. Remove the remaining part of the phalanx and complete the repair with use of a ventral flap. In allowing the tip to granulate in, a long time is required for complete healing, keeping a valuable worker out of work and frequently the final result is a painful tender tip. With full thickness on pedicle grafts good results can be obtained but the procedure is difficult, requires considerable time for complete healing and frequently the results are disappointing. When the usual type of repair is done with removal of the remaining part of the phalanx and the preparation of a ventral flap the finger is necessarily shortened from three fourths to one inch. The nail bed must be removed and the final result is a finger stump. When the thumb is involved the function may be considerably impaired.

In order to obviate the above difficulties the following method was done on a number of cases with uniform good results.

The end of the crushed finger or thumb is scrubbed thoroughly with soap and water and every particle of foreign matter removed. All devitalized tissue is excised and the tip of the phalanx smoothed. Two triangular skin flaps are prepared, one on each side of the finger by making a "V" shaped incision on each lateral aspect with the apex pointing proximally. The skin flaps so produced are loosened but are allowed to remain attached and thus maintain their blood supply through its subcutaneous tissue. The flaps are then drawn across the end of the finger and are sutured together across the midline, with fine interrupted silk or dermal sutures. The "V" incision is closed with one or two sutures. The two triangular flaps are further secured by several sutures around the circumference of the finger except at the dorsal aspect where the finger nail will eventually come through. A liberal supply of sulfathiazole crystals is used and a large dressing is applied which is not disturbed for from five to seven days. Healing usually takes place without infection. The end result is a rounded non-tender finger tip with a finger nail on a finger which has not been further shortened but slightly lengthened by the repair.

Real Lead Poisoning Is of Three Types

Real lead intoxication or lead poisoning consists of three types: (1) lead colic, making up 90 per cent of the cases, (2) lead palsy, making up 5 to 7 per cent, and (3) lead encephalopathy making up 2 to 3 per cent. All experts in the field of industrial toxicology agree that it is essential to distinguish between nondisabling lead absorption, which is not lead poisoning, and disabling lead intoxication, which is lead poisoning.

Besides the characteristic pattern of symptoms outlined above, there are certain helpful physical and laboratory signs which point to lead absorption. One is the lead line of the gum, which is a definite row of dots determined precisely by the use of the hand lens. Another is the demonstration of stippled cells on a blood smear ranging from five to ten per 50 fields or 500 to 1,000 per million red cells. These are best shown by the use of a Wright blood stain with which every physician is familiar when he makes a differential blood count. While neither a lead line nor a few stippled cells indicate anything more definite than probable lead absorption, they certainly do not in themselves indicate lead poisoning. The one laboratory sign which is consistently associated with clinical lead intoxication, or lead poisoning, is at present the stippled cell curve usually rising from 20 per 50 fields to over a 100 per 50 fields. The determination of lead in the urine is helpful as a confirmation of lead absorption. Of itself, quantitative examination of the urine for lead does not diagnose lead intoxication.

In another paper I have discussed in detail the treatment of acute lead poisoning and its residuals.—Elston L. Belknap, M.D., Milwaukee; Wisc. Med. Jour., Vol. 42, No. 12, Dec., 1943.

God be merciful unto us, and bless us and cause his face to shine upon us, that thy way may be known upon earth, *thy saving health* among all the nations.—Psalms 57.

The Nature and Clinical Use of Penicillin

JOHN P. TUCKER, M.D.

A COMMON experience in nature is the constant struggle for existence. In the air, in the sea, and on land we observe the predatory activities of birds, fish, and mammals. Only in recent years have we realized that this same inexorable battle for survival exists in the microscopic world.

The phenomena of bacterial antagonism are widespread throughout nature. In mixed cultures of organisms from such organic media as manure, sewage, and earth, soil bacteria and fungi are at war. In this media certain colonies have a destructive effect upon others. The law of survival of the fittest also applies here. The cause of this antibiosis is not clear. The struggle between organisms for the available supply of oxygen and nutrients may be one cause of antibiosis. Certain bacteria may liberate sufficient amounts of acidic or basic substances or noxious metabolites to destroy weaker colonies. Obviously, the magnitude of this warfare is beyond comprehension, yet the application of this principle to the destruction of organisms pathogenic to man has created intense interest in the medical world.

HISTORY

Occasionally during the past 50 years bacteriologists observed lysis of colonies on culture plates contaminated by other organisms. However, not until 1929 was careful investigation of this phenomena recorded in literature. Publication of observations by Alexander Fleming[1] from the laboratories of the St. Mary's Hospital, London, excited little clinical interest and received scant attention until the onset of the present World War, which necessitated mobilization of all effective methods for treatment of infectious diseases.

Although there are some 600 varieties of Penicillium only a few possess strong antibacterial qualities. After extensive investigations it was observed that the species Penicillium notatum possessed much stronger lytic powers than Penicillium rubrum. At present Penicillium notatum is used exclusively in the commercial production of penicillin.

DESCRIPTION

Culture: When Penicillium notatum is grown in a media containing "corn steep liquor," lactose, and inorganic materials, the culture obtained is used exclusively in the commercial production effective material. The potency may be one hundred times greater than in Fleming's original product, and there are indications that even stronger preparations are forthcoming. The Penicillium grows for a period of two weeks, and the culture medium is tested frequently. Since the media tends to become more alkaline daily the pH is maintained at a constant level by adding acid. The addition of lactose further increases the potency of penicillin.

The penicillin is extracted by organic solvents, and a barium, sodium, or calcium salt is made and dissolved in sterile water. Penicillin also can be purified by agitating the liquor with powdered charcoal and then extracting it with an organic solvent such as amyl acetate. The purified solution may be dried by several methods one of which is similar to that used in the production of dried or lyophilized blood from human plasma. The dried penicillin is a yellow powder which is bitter tasting.

Although penicillin is a rather strong organic acid, chemical synthesis of the product has been unsuccessful. Its chemical formula has not been definitely established, but chemists have suggested that it may be $C_{14}H_{19}NO_6$ or $C_{14}H_{17}NO_5 + H_2O$.[2]

The production of penicillin indicates why the supply of the drug is limited. At the present time all penicillin is sent to the government for the treatment of our casualties or for research under the auspices of the National Research Council.

Potency: At present the potency of penicillin is 45 to 50 thousand units per gram, but recent experiments indicate that the strength will be greatly increased. Florey[3] established the unit as "that amount (of penicillin) which dissolved in 50 cc. of meat extract broth just inhibits completely the growth of a test strain of Staph. aureus". The clinical dose is always estimated on the basis of this unit.

In the fresh dried state penicillin is hygroscopic. Since its antibacterial power is lost in 10 to 12

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days at room temperature, the ampules should be kept in a refrigerator. Likewise, penicillin must be maintained in a sterile condition until used. Since its bactericidal power is destroyed by boiling or by autoclaving at a high temperature, it can not be resterilized.

Antibacterial Qualities: Bactericidal tests show the effect of penicillin is about 100 times greater than that of the sulfonamides. The purest penicillin in dilutions of 1:20 to 1:30 millions inhibits Staph. aureus and in dilutions of 1:160 million partially inhibits bacterial growth.[3]

The organisms destroyed or inhibited by penicillin are principally certain pyogenic cocci.[4] The principal strains susceptible to penicillin are pneumococcus, Str. hemolyticus, Staph. albus, meningococcus, gonococcus, Str. viridans, B. subtilis, V. septique and six other strains of less clinical significance. The important strains insusceptible to penicillin are H. influenzae, E. coli, B. typhosus, B. paratyphosus A, B. dysenteriae, B. proteus, Staph. albus, and Friedlander's bacillus. Unfortunately, many micro-organisms pathogenic to man are not inhibted or destroyed by the antibacterial action of penicillin. The effects of penicillin in vitro as indicated by laboratory experiments have been verified by clinical tests. With the exception of Str. viridans endocarditis penicillin has effected a large percentage of cures in diseases produced by penicillin-susceptible strains of bacteria. This correlation of laboratory and clinical observations is remarkable.

Related Antibacterial Substances: Investigations have been made with a wide variety of bacteria such as Aspergillus, B. pyocyaneus, B. prodigiosus, B. vulgatus, and Actinomycetes. Unfortunately, the filtrates from cultures of each of these may act as protoplasmic poisons when given parenterally in man.

In 1939 Dubos[5] of the Rockefeller Institute isolated a strong antibacterial substance from cultures of B. brevis. He found that culture filtrates from this organism in vitro destroyed gram-positive organisms but had little effect against gram-negative types. This substance contained two active components, gramicidin and tyrocidin. Gramicidin proved to be very destructive to gram-positive bacteria, while tyrocidin was moderately effective against the gram-negative type. Unfortunately, when gramicidin was used intravenously in experimental animals it not only caused lysis of red and white blood cells but also produced cloudy swelling of the liver, spleen, and kidneys. Like many other culture filtrates it acted as a protoplasmic poison. Although gramicidin can be used locally on infected wounds, some of the toxin may be absorbed into the blood stream. As a result it is used very little in human disease but is an effective remedy for bovine mastitis.

While more potent antibacterial agents may be found in the future we must accept the fact that at present penicillin is the only safe preparation of this type. Since it is nontoxic to man when given in effective doses, penicillin is best for clinical use.

CLINICAL USES

Penicillin may be administered by intravenous, intramuscular or intrathecal injection or by direct injection into the pleural cavity or joints. Administered topically penicillin has potent bactericidal and bacteriostatic effects.

Large quantities of the drug and efficient hospital teamwork are required for the intravenous administration of penicillin. The dry penicillin powder is dissolved in sterile normal saline or in a 5 per cent dextrose solution. Concentrations of 1000 to 5000 units per cc. are employed. This perfusion is continued day and night until the infection has subsided or has become definitely localized for surgical drainage. Depending on the type and severity of the infection the therapy may be continued from 3 days to 3 weeks. This prolonged treatment requires changing of the infusion needle from one vein to another to prevent local thrombophlebitis. "The dosage schedule varies from 1000 to 25,000 units per hour depending on the kind and severity of infection."[6] Much depends on the early favorable response of the patient. A total of 12,000 to 240,000 units every 24 hours is the range of dosage. Owing to the absence of any severe toxic effects overtreatment is not dangerous.

Intramuscular injections are satisfactory in less severe infections but must be given in small volume, that is, 5000 units per cc. of normal saline solution. Since penicillin is rapidly absorbed and excreted the injection is given every 3 to 4 hours. As a rule the local reaction is slight and causes little complaint.

When used in inflammatory diseases of the central nervous system penicillin must be injected intrathecally since no effect follows intravenous use. The absorption from the subarachnoid space is slow. Approximately 5000 to 10,000 units is used although the larger dose may cause moderately severe headache, vomiting, and increase of cells in the cerebrospinal fluid.

After expiration of pus from the pleural cavity a solution of 30,000 or 40,000 units is injected once or twice a day. Since 6 to 8 hours is required to obtain maximum effect, penicillin solutions are not used for irrigation of the empyema cavity.

Although dry powdered penicillin is irritating to a wound when applied topically, solutions of 250 to 500 units per cc. may be used safely.

When given orally penicillin is destroyed by the gastric acids. After oral use in a case of per-

nicious anemia appreciable quantities were recovered in the urine which showed that penicillin is inactivated by hydrochloric acid but not inhibited by pepsin. Penicillin is not destroyed by the alkaline juices of the duodenum, since it is effective when given by duodenal tube and readily excreted in the urine. Administration by rectal tube is valueless. The bacterial flora of the large bowel destroys penicillin before absorption or local action can take place.

After intravenous use penicillin cannot be demonstrated in the tears or saliva, nor does it enter the subarachnoid space. When instilled into any serous cavity penicillin is nontoxic and nonirri tating. Effective bacteriostasis has been found to result from injections of penicillin into the pleural and joint cavities, and in each case it is slowly excreted in the urine.

The chief clinical problem seems to be the maintenance of a sterilizing dose of penicillin in contact with the pathogenic organism for a sufficient length of time. This procedure is rendered difficult by the rapid loss of penicillin through the kidneys. After intravenous or intramuscular injection penicillin is excreted rapidly by the kidneys and approximately 58 per cent can be recovered in the urine in 4 to 5 hours. Penicillin extracted from the urine is not altered physically or chemically and can be used again in experimental animals.

A second organ for the excretion of penicillin is the liver. A higher concentration of penicillin appears in the bile after intravenous use than is present in the blood. Therefore, penicillin may prove to be highly effective in the treatment of suppurative diseases of the biliary tract.

The most comprehensive clinical record of the use of penicillin is a report of 500 cases by Chester S. Keefer and his collaborators.[6] In the majority of these cases penicillin was used only after the patients failed to respond to the sulfonamides. Keefer and others noted that penicillin was most effective in diseases caused by Staphylococcus, gonococcus, pneumococcus, and hemolytic streptococcus. Recovery or improvement occurred in all 129 cases of gonococcic infections, while in 17 cases of Str. viridans endocarditis penicillin failed completely to produce recovery. Results in the treatment of diseases caused by Staph. aureus, Str. hemolyticus, pneumococcus, meningococcus, and miscellaneous types were notably satisfactory.

Penicillin not only diffuses through infected and broken down organic tissue with remarkable facility but also produces no local irritating effects. Unlike the sulfonamides penicillin is not inactivated by bacteria, dead tissue or tissue autolysates, nor does it have any inhibiting or unfavorable effects on red blood cells or leukocytes. In short, penicillin passes through the body unchanged, its effect is bacteriostatic or bactericidal, and it is nontoxic.

SUMMARY

Penicillin is the most potent antibacterial substance available for injection into the body. It is nonirritating, it perfuses readily into infected and autolyzed tissue, and it is finally excreted unchanged in the urine.

The pyogenic cocci such as Staphylococci, pneumococci, hemolytic streptococci, and gonococci are particularly vulnerable to penicillin.

Penicillin should be used only when a trial with the sulfonamides has failed.

It is effective when used intravenously, intramuscularly, intrathecally, topically, and when injected into the pleura, joints, or pericardium.

Owing to rapid elimination in the urine and bile, penicillin must be administered continuously by intravenous route or must be injected intramuscularly every 3 to 4 hours.

The method of administration and the size and frequency of the dose must be determined by the therapeutic response in each individual case.

The effect in the body is largely bacteriostatic, although when used locally it is also bactericidal.

As a rule any toxic effects are due to impurities that are present in the saline or dextrose solutions used as solvents.

CONCLUSION

At the present time intense effort is being made to purify penicillin so that accurate analysis and chemical synthesis can be realized. This may lead to quantity production of penicillin as well as to the development of a new series of chemotherapeutic agents for the treatment of human disease. The clinical research in at least 20 civilian hospitals under the auspices of the National Research Council and the experience derived from the use of penicillin in army and naval hospitals will demonstrate the advantages and limitations in the use of this remarkable preparation. By keeping abreast of the literature, physicians in civilian practice will be prepared to employ penicillin intelligently when it is available for general clinical use.

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A Critical Examination of the Factors Underlying Blood Donor Syncope and Their Bearing on the Treatment of Surgical Shock

ROBERT D. BARNARD, M.D.

THE psychogenic nature of syncope has always been surmised from the fact that it may be provoked by agencies other than physical ones. Disgusting sight and odors, bad news and fear are known to give rise to swooning in susceptible individuals. A more than academic interest in the syndrome is timely, in light of the recent finding that the phenomenon is diphasic in a definite percentage of instances; that the initial phase bears more than a superficial resemblance to clinical idiopathic epilepsy and that the terminal phase is not unlike surgical or traumatic shock. The latter is at any time, and particularly during war times, of tremendous clinical importance. War conditions, likewise, offer a suitable laboratory for the study of shock and of syncope. During the present conflict we have, fortuitously enough, under controlled observation a large number of syncope subjects. In the voluntary blood donor centers which have had their inception as a result of the war, fully 7 per cent of the patrons develop the syncope syndrome either before, during, or after the bleeding.

NON-TRAUMATIC SYNCOPE

While the last factor would seem to complicate the picture and render unjustifiable its designation as "non-traumatic" syncope, certain arguments may be advanced to show that bleeding is a psychologic rather than a physical incitant. As has been mentioned, many donors will faint before the actual withdrawal of the blood. The syncope syndrome under these circumstances is indistinguishable from that evidenced after the withdrawal of a full pint of the fluid. Large individuals from whom the withdrawal of a fixed quantity of blood represents a smaller fraction of the total blood volume show just as much tendency toward syncope as smaller individuals. Many females who give a history of several major surgical operations or several difficult labors from which their nervous systems have emerged unscathed will, nevertheless, state that they faint at the sight of blood and will go ahead to substantiate this statement in a blood donor center. It appears probable that the idea of blood loss is a powerful and firmly entrenched instinctive taboo, the purposeful violation of which entails a vigorous psychic combat with resulting psychic exhaustion.

Again in line with this argument is the fact that syncope is unprecedented in professional donors and not particularly frequent in the emergency donations that were the matter of course before the advent of blood banks. In the latter case, it is probable that the constant conscious painful psychic stimulus of the grave illness and danger to a loved one took precedence over the unconscious one of "blood-loss" for just as in the case of specially differentiated painful physical stimuli, the more powerful becomes preponderant to the exclusion of the lesser, so in psychology is this principle true.

Professional donors do not faint because they are a self-selected group of individuals. Likewise, it is believed that voluntary blood donors in the national program are also, to a large extent, self-selected. It has been pointed out that the predisposition to donor syncope is found most frequently in "vagotonics".[1,2] We may go one step further and state that the relatively high incidence of syncope reactions in our national blood donor centers over that which obtains among emergency donors is due to a disproportionately high percentage of a certain type of physically and psychologically constituted individual among the patrons of the former.

STIGMATA

The stigmata that characterize the physical and psychic type known variously as "parasympathetic," "vagotonic," and "asthenic," while elusive from a standpoint of physiometric and psychometric definitiveness are nevertheless amenable to clinical appraisal. Such an individual may not exhibit all the criteria of low systolic blood pressure, lowered body temperature and low basal metabolic rate that the textbook pic-

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ture prescribes, but the psychologist recognizes in his behavior a distinctly peripatetic pattern; as a child, he had what the pediatricians term a "neuro-arthritic diathesis" and the dermatologist finds him a subject to the "neuro-dermatidites". This is the individual who makes up for his relatively slow metabolic processes by an overcompensatory drive and he forces himself through a sense of duty into the blood donor center because he is afraid to donate blood. But he is even more afraid of being thought by others to be afraid, even by his own conscience, and his purposeful attempts to disguise his fear unquestionably doubles, for him, the psychologic strain of blood donation.*

The ordinary cursory examination given to blood donors and the simple recording in each case of the blood pressure, plus rate, hemoglobin level and temperature will not serve, either immediately or on subsequent analysis to differentiate this individual from his pyknic or "sympathetic" counterpart. For this reason, all attempts to demonstrate differences in these meager criteria between the syncope subject and those donors who do not react by syncope are bound to be negative.

It is the purpose of this report to show that other, more subtle criteria for such a differentiation do exist; that the physical stigmata of the "vagotonic" render him peculiarly susceptible to psychogenic syncope and that a critical analysis of these stigmata throw some light on the mechanism of the shock phase of syncope and thus open a rational approach to its treatment.

The psychologic stigmata of donor syncope subjects is under investigation in conjunction with other agencies and will be the topic of a separate report, which will include an analysis of those **idiopsychic** factors which we know to be involved. The latter are ignored for the purposes of the present report which is confined to those physical (and psychosomatic) factors which have been invoked to explain the syncope syndrome in blood donors, both by others and by the present writer. These will be enumerated and analyzed. The order in which the enumeration is carried out is not one of sequence of importance but of convenience in analysis.

A. **Fatigue and Fasting.** These are listed as the principal etiologic agents of donor syncope by Poles and Boycott[1] of London. How much the aggravation of a syncope tendency by fatigue and/or fasting is physical and how much psychic can not be stated from presently incorporated experience. That they do play a part is a statistical fact though the nature of this part is obscure. Both fasting and fatigue are conducive to hypoglycemia and its corollary, relative hyperinsulinism. Insulin is a powerful parasympatheticomimetic agent. As previously reported[2] syncope appears to be, in part, a cholinergic phenomenon. We have seen an occasional instance of indutiably recognizable hypoglycemic reaction in voluntary blood donors.

B. **Lesser Blood Volume.** Poles and Boycott[1] considered those donors who reacted to bleeding by syncope to have a smaller relative blood volume than those not affected. They base this finding, not on an actual determination of blood volume but on a concomitant standard; the body surface. If the last parallelism is a valid one, it may be only an incidental one in that it may indicate adjuvantly that the vagotonic who has a low basal metabolic rate as a result of a relatively small body surface, is the chief syncope subject.

C. **Intramuscular Pressure and Muscularity.** The work of Gunther[3] who showed that surgical shock was accompanied by a fall in intramuscular pressure and that this in turn resulted in a diminution of venous pressure with a failure of the venous return to the heart (forward failure), has opened a new epoch in the understanding and treatment of shock. The fact that there is a concomitant drop in both the intramuscular and venous pressures during the second phase of syncope fortifies the conclusion previously enunciated that this phase represents a true shock in its initial and uncomplicated stages. But the observation has been carried further. In the vagotonic; the syncope prone individual, the muscular configuration is such that the maintenance of an adequate venous pressure is less dependent upon muscular tone. The fact forces itself upon the attention of one doing thousands of venipunctures that in a high proportion of syncope reactors the accessible veins lie chiefly within a thickened panniculus adiposis and do not lie, as in the case of the muscular subject (who seldom, if ever, reacts to donation by syncope) directly contiguous with or partially within the muscle fascia itself. In the latter type (Figure I) the skin and superficial fascia may be slid over the underlying vein without disturbing its relationship to the muscle; in the majority of syncope subjects even such large veins as the median cephalic and the median basilic lie within the superficial fascia and are directly movable with the skin when that of the anticubital fossa is distorted by traction. This anatomical distinction has been traced in these veins for a considerable though variable

*It is possible that the successful emergence from the psychic conflict entailed by blood donation decreases the subsequent potency of the blood-loss taboo. Syncope reactions are far more common in initial donors. The importance of psychic exhaustion as a predisposing factor is illustrated by the following case:

J. B., age 35, an eye specialist weighing about 185 pounds and exhibiting typical vagotonic stigmata, gave two donations at 12-week intervals without ill effects. During the interval between the second and third donations, he was under considerable strain in business and professional relationship and developed some scattered lichen planus lesions that received only local treatment. During his third donation twelve weeks after the second, he had a syncope reaction before completion of the bleeding.

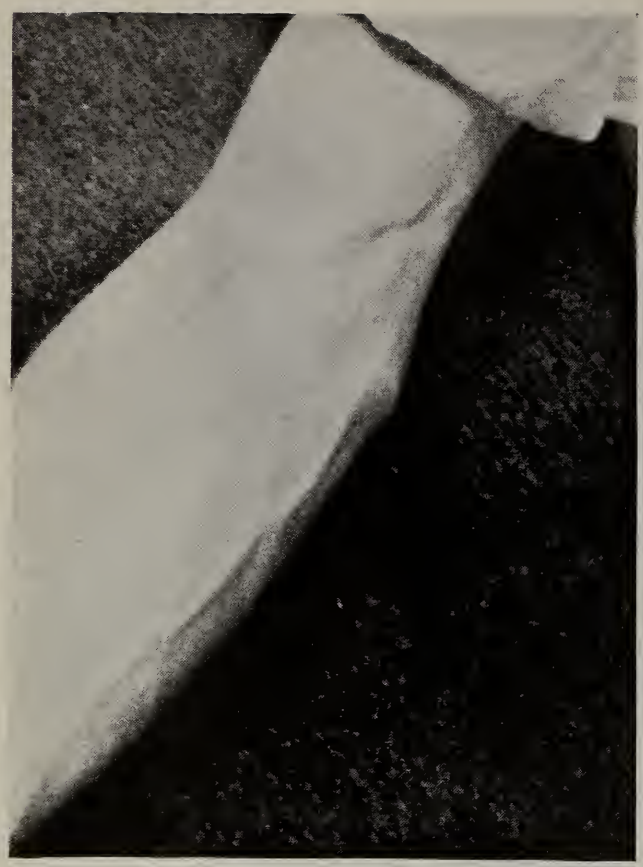


Figure 1. Arm of a non-reacting blood donor of the sthenic or "sympathetic" type. The prominent ulnar condyle exemplifies the general muscularity. The visible veins are proper to the skin and are found in all those instances where the skin vascularity is comaratively rich. These veins are not those ordinarily used for ventipuncture; the latter in this type of individual lie deeply, usually upon or within the muscle fascia or even within the muscle substance, itself. It has been observed whether significantly or not that almost all donors with polycythemia vera have musculo-venous distribution of the type illustrated.

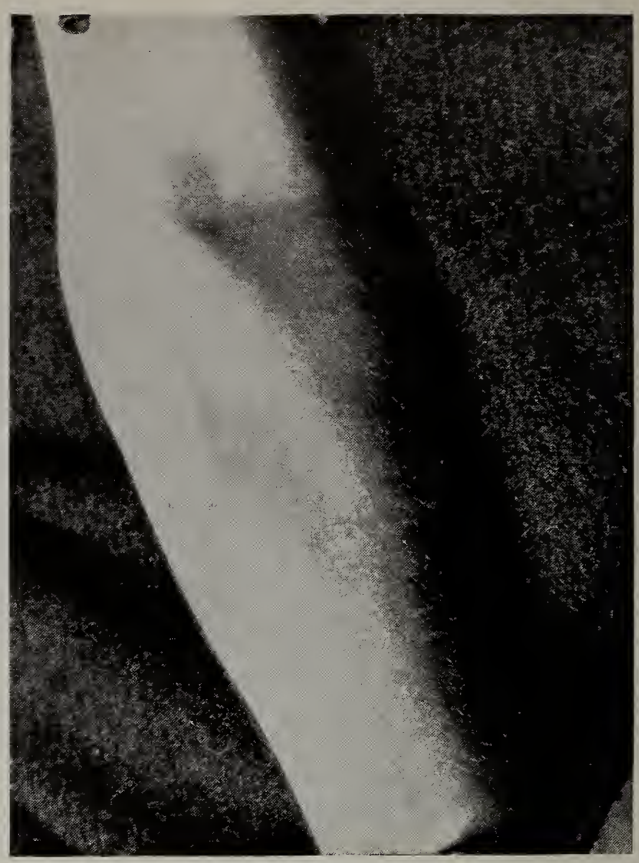


Figure 2. Arm of a syncope reacting blood donor of the same approximate age and weight and bled simultaneously with the one whose arm is shown in Figure 1. Note the relative absence of the prominence of the ulnar condyle and of veins proper to the dermis. The veins of the anticubital fossa lie within the panniculus adiposis which is usually but not always thicker in the vagotonic individual. It has been noticed that the veins illustrated in this connection are, in general, less fibrous and more distensible than the corresponding ones in the sthenic type.

I am indebted to Dr. Carl W. Brown of Lancaster, Ohio, for these excellent photographs.

distance from the seat of their greatest superficial approach in the fossa (Figure 2).

While such a structural relationship, viz., a venous system surrounded by fatty or areolar tissue, could explain the relative inefficacy of intramuscular pressure to maintain the venous pressure as adequately as that musculo-venous relationship which must necessarily exist where the cushion of areolar tissue is not present to buffer the effect of muscular contraction or tonus, that it is probably not the exclusive factor is indicated by the presence of still another which operates to maintain venous pressure, a factor to which little attention has been paid, except indirectly. This important factor is

D. Skin Vascularity (Skin Capillary Pressure). It has been noted rather casually during the routine examination of donors' arms, incidental to venipuncture and more closely during this study, that the skin of "vagotonics" is decidedly less vascular than that of the "sympathetic" type of individual. The observation is not a new one. The alabaster brow and marble-white skin of the fair lady who swoons in every other scene, is attested by no less an exact observer than Shakespeare. It had been noticed for some time that there was a considerable variation in the skin vascularity of donors; particularly was this apparent while infiltering novocain solution into an intradermal wheal as is done previously to and at the site of the intended venipuncture. Some novocain solution may escape from the wheal after the infiltering needle is withdrawn and this may be blood tinged in those instances where the skin vascularity is great; seldom if ever does this occur in the "vagatonic" type.

That the skin vascularity is an important and, perhaps, the major factor in the maintenance of the venous return flow from an extremity is attested by two facts: first, it is possible to increase the venous pressure, as gaged by the rate of flow during phlebotomy, by measures which dilate the skin capillaries (heat, rubefacients). Physicians assigned to blood donor centers have often commented on the difficulty of performing suitable phlebotomty and of maintaining a fair rate of flow on those days when the weather turns suddenly chilly and the donors come in from the out-

doors with constricted skin capillaries. Secondly, if syncope should develop during the actual donation, the flow of blood ceases almost entirely when pallor becomes evident even if the tourniquet on the upper arm is released sufficiently to allow for an adequate arterial blood supply. From this observation, it is actually adjudged that the skin capillary flow may be even more an effective factor in the maintenance of the venous pressure than is the intramuscular pressure. In any event, it is a fact that those who have a heavy musculature and in whom the veins are so situated that a contraction of the muscles will augment the venous pressure are likewise the subjects in whom the skin vascularity is good, while conversely, the vagotonic is under the double handicap in this respect of both inadequate musculovenous mechanism and inadequate skin vascularity.

SKIN PALLOR

Now there arises an apparent contradiction in the fact that the skin pallor in both shock and the shock stage of syncope are adrenergic phenomenon and we should expect an increase in the circulation rate and minute output of the heart as the result of the epinephrine secretion that has been postulated as being at the basis of the peripheral arteriolar contraction in shock. Freeman,[4] whose epinephrine hypothesis of shock has been fairly accepted, points out, however, that epinephrine itself may produce shock and that the administration of epinephrine or any of its homologues (ephedrine, amphetrine) are contraindicated in the treatment of shock. In two out of ten subjects, Blumgart[5] showed an actual decrease in the arm to heart circulation rate after the subcutaneous administration of epinephrine. We have observed the exact analogue of donor syncope after the administration of naphthazoline in four humans; in this instance accompanied by "gooseflesh" and other pilomotor phenomena. The latter is good evidence of the sympatheticomimetic activity of this particular drug. It is not inconceivable that along with the physiologic and psychologic stigmata noted, the "vagotonic" might be characterized by certain pharmacologic ones as well and such a stigma might be the anomolous response to epinephrine and its homologues.

SKIN VASCULARITY

With the concept that the skin vascularity and the intramuscular pressure are the important operative factors in preventing the type of circulation failure which is responsible for syncope and which, if protracted, will result in shock, attention is directed to Figure 3 in which there is rendered the most recent postulation of the manner under which these factors are abrogated. Under psychogenic stimulation from the higher centers, there is depicted an accelerated elaboration of acetylcholine both from the brain itself and also from the ordinary sites of its systemic production (somatic and cranio-sacral visceral motor nerve endings; visceral ganglia) faster than the hormone can be handled by the normal mechanism for its destruction, choline-esterase (various hemoglobin like compounds in blood, muscle and nerve tissue). The latter may be

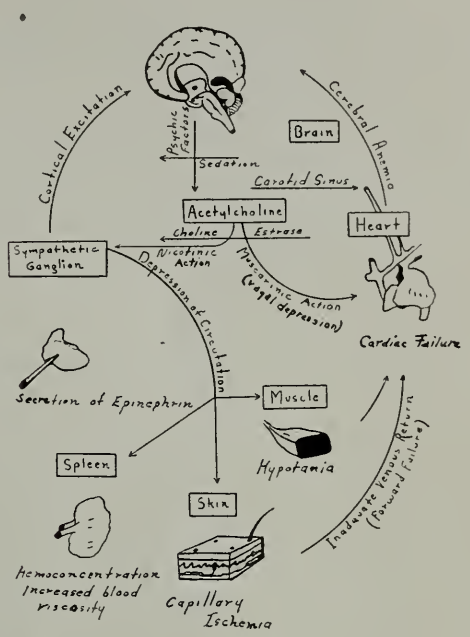


Figure 3. The Vicious Circles of Shock. These are seen to be initiated by psychogenic factors and may be disrupted only at each of two points on the common stalk, viz., an abolition of psychic factors through sedation or destruction of the systemically liberated acetylcholine by an increase of choline esterase. The latter is not clinically feasible; the former constitutes the keystone of treatment for it is directed against the etiologic foundation of the condition. Sedation likewise operates to remove the influence of idiopsychic impulses which certainly exist, whose nature is not well defined but which probably operates neurogenically to initiate and aggravate the humoral mechanism of shock. Treatment directed at disruption of the individual components of the vicious circles such as those devised to combat vagal cardiac suppression, forward cardiac failure, capillary ischemia, anoxia and intercellular exudation, though clinically important is at best, only symptomatic.

deficient in amount (anemia) or in an inactive form (esserine, cyanamide or histamine(?) intoxication). If, as a result, acetylcholine persists in the organism, it stimulates (1), the production of more acetylcholine and (2), the production of epinephrine (or sympathin). The latter in turn sets up its own vicious circle of stimulation of (2a), more epinephrine and (1a), additional acetylcholine. Thus there is engendered a network of vicious circles, which if allowed to continue in operation will lead to depressor circulatory changes and collapse (irreversible shock).

In ordinary syncope these vicious circles are not maintained for they are broken into and disrupted by the enzymatic agencies for the destruction of both acetylcholine and epinephrine; the choline esterase and the amine oxidase, respectively (if they are not actually two different aspects of the same enzyme). Where the activity of these enzy-

mes is interfered with or where they are deficient in amount, collapse is bound to occur.

Such an etiologic concept makes it possible to approach, rationally, the active treatment of syncope, which is in effect, the prophylactic treatment of surgical shock. When this is done, it is found that well-established empirical procedures find a legitimate place in the rational scheme of treatment. These may be classified as:

1. Measures Designed to Limit the Psychogenic Inciting Factors of Shock and to Reduce the Production of Acetylcholine.

(1) Sedatives and Anodynes. Morphine is unrivalled for this purpose in shock and should be used unhesitatingly in any conscious patient. For the prophylaxis of donor syncope, it is obviously unsuitable and the less effective bromides or barbiturates may be used instead.

(2) Psychotherapy. Reassurance, a cheerful atmosphere and a purposeful, yet unostentatious, attempt to help the patient is the keystone of psychotherapy. Like other forms of treatment, it must be applied to the patient and not to the condition. Some patients suffer additional psychic trauma if the attendant is jocular and minimizes the condition; others are frightened by ordinary solicitousness. In this connection, the author depreciates two common practices; the inhalation of ammonia (particularly by an unconscious patient) and standing the patient on his head. There are some definite physiologicochemical objections to ammonia and ordinary recumbency in whatever position the patient finds most comfortable is sufficient to prevent circulatory failure on hydrostatic grounds, alone. The patient's comfort must be kept in mind, likewise, if externally applied heat is going to be used. This time-honored procedure has fallen into some disrepute of late.[6]

II. Measures Designed to Facilitate the Destruction of Acetylcholine and Epinephrine and to Break Up the Vicious Circles Caused by their Excessive Production and Persistance in the Organism.

In this category, we find also necessarily placed, those measures which improve (?) the circulation. Naturally enough, both choline-esterase and amine-oxidase being carried by the blood as well as being present in the tissues, a condition which also presumably obtains for their substrates, a more rapid circulatory rate would facilitate the more complete general interaction of the enzymes and the materials which they decompose at the same time as the other salubrious ends of better tissue oxygenation and renal elimination are being subserved. For this purpose, atropine has its advocates; it abolishes the muscarinic, but not the nicotinic effects of acetylcholine. It is the latter effect which causes the production of epinephrine. It should abolish the vagal effects of acetylcholine, but it is probable that the circulatory failure in shock is not due to cardiac supression in this regard. In fact, the action of atropine as a circulatory stimulant is irregular and it may even operate in ordinary doses to depress the circulation. Atropine has no antidotal effect in cyanamide shock in experimental rats;[7] a type that is due to sustained cholinergesis and which is believed to be fairly comparable to surgical shock in the human. The use of strychnine, a powerful anti-choline-esterase drug, arouses grave theoretical objections which are apparently validified by its clinical inefficacy in stimulating the shock subject. Epinephrine, as has been mentioned, is also objectionable on theoretical grounds and is even said to precipitate shock. Alpha-lobeline, metrazol, camphor, caffeine and the digitalis group of drugs all have their advocates. Coramine, of which more will be said later, probably belongs among this group.

RESTORATION OF BLOOD VOLUME

(1) Restorers of blood volume. Physiologic salines. Blood. Blood plasma and serum. These were originally designed to maintain the blood pressure by volume effect. The arguments against the use of ordinary saline have been summarized by every recent textbook of physiology; that it is diffusible and leaks out of the circulation into the tissue and through the renal glomeruli and is, therefore, evanescent in its action. Much as these facts may be true, that the venous infusion of ordinary saline is a valuable and even life saving measure in shock is known to every clinician who has dealt with surgical cases prior to the advent of plasma. If it did leak out of the circulatory bed, it was cheap enough to replace and a temporary action in priming the circulation was usually all that was needed. Plasma, of course, does not have these objections and it contains choline-esterase and amine-oxidase; many surgeons feel that it possesses a shock-counteracting action apart from its oncotic properties. Unfortunately, most of the esterase of blood is thrown away with the corpuscles and it is hoped, in this connection, that experimental work will continue with hemoglobin solutions as blood substitute. While whole blood might be thought to be the therapeutic agent, par excellence from this standpoint, it can not be used in irreversible shock because of an already present hemoconcentration.

(2) Choline-esterase. While enzymes which destroy acetylcholine have been prepared in injectable form, their administration in human surgical shock has not as yet been attempted. Coramine, which, it is believed, operates by raising the choline-esterase content or potency of the blood and tissues, has, however, been used in surgical shock and in donor syncope. Gunther[3] reports on the beneficial effects of coramine both on the clinical manifestations of shock and on the

diminished intramuscular pressure of shock subjects. He has used doses, intravenously, far above those ordinarily advocated or generally employed. Paralleling the observations of Gunther on shock are the writer's with donor syncope. The material is administered by mouth in doses of 5 to 15 cc. The procedure was instituted first as a placebo; it turned out to be far from that. The effect of oral coramine on the pallor, prostration and circulatory state of syncopic subjects is so dramatic and unequivocal that many questions as to the seat of its action have been raised. In fact, unless there is rapid sublingual or gastric absorption of the material, they can not be explained at all. It is known that coramine has the power, like nicotinic acid and certain other components of the vitamin B-complex group of substances, to carry ferriheme into solution at physiologic pH. It may, thus, engender choline-esterase. This explanation of its action seems likely, because coramine is also effective in the abolition of the nausea and abdominal cramps that frequently accompany syncope; manifestations that are definitely cholinergic in nature and this aspect of the pharmacology of coramine is under experimental study at present. It also appears that coramine shares with nicotinic acid, in addition to its anti-pellagric action, a slight but definite peripheral vasodilator effect and this effect may be as important in the maintenance of an adequate circulatory flow as is the maintenance of intramuscular pressure.

CORAMINE

The limitation of coramine is as a prophylactic. It is effective in combating the humoral but not the neurogenic agencies which together produce syncope or shock. It is, in fact, through experiments with coramine that we may separate the two agencies and unmask the factor which operates in addition to acetylcholine production in the initiation of the shock phase of syncope. It has been common knowledge that fright will cause the face to blanch and the heart to "skip a beat" practically immediately upon its imposition; such rapidly developing autonomic effects could hardly have a humoral mechanism. We must believe, instead, in this instance that the vasomotor and vagus centers in the medulla are stimulated through nervous pathways from the cerebrum and that the effectations result via nervous rather than humoral channels. The operation of such nervous channels in the maintenance of the autonomic imbalance in shock is indicated by the work of Stern[8] who uses the cisternal administration of potassium phosphate for the selective stimulation and supression of the adrenergic and cholinergic centers, respectively.

While we, like Gunther,[3] have found that coramine is the most potent single agent for combating the shock phase of syncope, we feel that the confinement to a single therapeutic procedure is unjustifiable clinical stereotypy. Blood donor syncope like its more aggravated homologue, surgical shock is encountered in lesser and greater degrees of severity: some of the latter cases when protracted would be indistinguishable from "true" shock, even by those who still contend that there is any essential difference in the conditions. The best therapeutic results are forthcoming in the treatment of donor syncope as they are in traumatic shock when it is appreciated that the common circulatory depression is finally, if deviously, the result of a primary psychic incitant.

SUMMARY AND CONCLUSIONS

1. Voluntary blood donors are a self-selected group, a high proportion of whose members are vagotonic individuals presenting characteristic psychologic and physical stigmata.

2. The physical stigmata of vagotonics include an inadequate musculo-venous mechanism and diminshed skin capillarity which predisposes them to forward circulatory failure and collapse.

3. The hormonal nature of the accentuation of the predisposing factors to syncope are analyzed and found to be comparable to those operating in surgical shock. The acetylcholine theory is in itself inadequate to account for all features which, however, are explained by assuming the operation, in addition of idiopsychic nerve impulses.

4. Coramine is the most effective single pharmacodynamic agent for the treatment of donor syncope. It is postulated that this efficacy may be due to a supposed ability of coramine to engender a choline esterase.

5. As in the homologous condition of traumatic shock, sedation and psychotherapy play an important part in the treatment of donor syncope.

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ADDENDUM

Since the preparation of this manuscript, J. R. Di Palma (J. A. M. A., 123:11, Nov. 13, 1943) has published an exhaustive study of the circulation in the skin in shock syndrome subjects.

Report of the Hospital Obstetrical Society of Ohio

Compiled and Edited by

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IN 1937, the Hospital Obstetrical Society of Ohio began collecting data from its member hospitals relative to the work they were doing. Each submitted a monthly report of the cases handled. The number of cooperating institutions has varied between forty and fifty. Analysis of these reports was published for the years 1937[1] and 1938.[2] Due to the War, it has been found impossible to carry on the activities of the Society. The collection of data was discontinued early in 1943. This paper is a final summary of the reports on hand which had not previously been published. It includes figures from January, 1939, to April, 1943.

During this period, the following puerperal cases were reported.

Early Abortions (prior to 4½ months)	9,851
Late Abortions (4½ to 6½ months)	1,551
Ectopic Pregnancy	940
Viable Deliveries (past 6½ months)	191,153

In addition there were 780 women delivered at home and then admitted for post-partum care, in many cases because of serious complications. There were also 851 patients hospitalized for the treatment of hyperemesis. This gives a total of over 205,000 women cared for during the period of this study. The 1937 report covered 37,500 cases, 1938, approximately 42,000.

The term abortion, is of course, used in its broad sense to include all interruptions of pregnancy prior to viability. One abortion case was cared for by our hospitals for each 16 viable babies born. Similarly, there was an average of one estopic for each 200 babies.

MULTIPLE BIRTHS

In this series, there was 1,627 sets of twins and 6 sets of triplets reported which would be one twin in 120 cases, and one triplet in 32,000 deliveries.

METHOD OF DELIVERY

There were 194,339 reportable births (4½ months or over). These were delivered as follows:

Spontaneous	92,208	47.5%
Operative	102,131	52.5%

Further analysis of the operative deliveries reveals the following:

Forceps:

High	585	.3 %
Mid	7,334	3.77%
Low	43,350	22.27%
Low Elective	36,969	19.0 %
Total	88,238	45.34%

These rates do not differ significantly from 1937 and 1938.

Caesarean:

Classical	2,342	1.2 %
Low Cervical	1,274	.66%
Other	166	.09%
Total	3,782	1.95%

These figures would appear to indicate a slight decrease in the incidence of Caesarean—(1937, 2.61%; 1938, 2.39%).

Other Operative Delivery Methods:

Breech	7,036	3.62%
Podalic Version	2,234	1.2 %
Braxton-Hicks Version	33	.02%
Embryotomy	98	.05%

Operative induction was employed in 0.6 per cent and operative interference, other than delivery and perineal repair, was employed in 0.8 per cent of the cases reported. This is about the same ratio as previously reported. Some of these cases were subsequently delivered spontaneously.

When the spontaneous and simple forceps are considered together, we get a better picture of the amount of real operative obstetrics done.

Spontaneous & Simple Forceps	173,245	89.2%
Remaining Operative	21,094	10.8%

This is a definite decrease in operative cases. 1937 showed 14.8%, and 1938, 13.5% major operative work.

OBSTETRICAL COMPLICATIONS

Among the 191,153 viable deliveries, the following complications were recorded:

Hemorrhage:

Plac. Prev. Cent.	341	.18%
Plac. Prev. Marg.	558	.29%
Total Previa	899	.47%
Premature Sep.	903	.47%
Total A.P.	1,802	.94%
Early P.P. (1st 24 hrs.)	1,383	.72%
Late P.P. (after 24 hrs.)	160	.08%
Total P.P.	1,543	.80%
Hemorrhage Total	3,345	1.74%

These percentages are practically identical in each case with those previously reported.

Toxemia:

Without Convulsions	3,205	1.67%
With Convulsions	520	.27%
Total	3,725	1.94%

Morbidity Temperature:

"Morbidity Temperature", is defined as any elevation of mouth temperature, regardless of cause, to 38°C (100.4F), or over on any two consecutive days not including the first 24 hours after delivery. Cases falling into this class were broken down further into those of known extra genital, and known extra hospital origin. The figures were as follows:

Morbidity Temperature	5,648	2.93%
Of these patients, the infection was of		
Extra Genital Origin in	1,989	35.2 %
Extra Hospital Origin in	695	12.3 %

Other Serious Complications:

No attempt will be made to analyze the cases reported under this heading. It includes intercurrent diseases, as: diabetes, heart and kidney conditions, tuberculosis, hyperthyroid, etc. They are of importance in that they throw additional responsibility on the obstetrical department and physician in the handling of the cases.

Other Serious Complications	4,389	2.2%

CONDITION ON ADMISSION

Known Pathology on Admission	7,506	3.9%
Normal on Admission	5,535	2.9%
Total	13,041	6.8%

These figures are definitely less than those previously reported, particularly the percentage of those normal on admission who subsequently had trouble. From the above figures, it is seen that, of the complicated cases handled, 57.6 per cent had known pathology on admission. Of the patients normal on admission, 97 per cent remained so throughout their hospital course.

FETAL COMPLICATIONS

In the group of 194,339 reportable births, the following fetal complications were reported:

Prematurity:

Previable Prematurity	1,594	.82%
7 months	2,697	1.39%
8 months	3,750	1.93%
Total Prematurity	8,041	4.14%

Infections

Impetigo	916	.47%
Enteritis	275	.14%
Pneumonia	81	.04%
G.C. Ophthalmia	90	.05%
Other Infections	357	.18%
Birth Injury	893	.46%
Deformity	2,579	1.33%

These averages in each instance, are the same, for all practical purposes as those reported in 1937 and 1938.

MORTALITY SUMMARY

Fetal Deaths

Stillbirths	4,790	2.46%
Neo-Natal	3,815	1.96%
Total	8,605	4.42%

Both stillbirths and neo-natal deaths have shown a slight decline:

	1937	1938	1939-43
Stillbirths	2.83%	2.68%	2.46%
Neo-Natal	2.19%	2.11%	1.96%
Total	5.02%	4.79%	4.42%

While this percentage change appears small, it must be realized that had the current series had the same mortality as 1937, over 1000 additional babies would have been lost.

Maternal Deaths:

Due to Obstetrical Cause	314
Non-Obstetrical Cause	139
Total	453
Puerperal Death Rate	**2.38/1000**

This includes all deaths during, or because of, pregnancy calculated against live births. The above figure is less than half the corresponding rate in 1937 which was 5.38 per 1000. This is in accord with the nation wide fall in maternal deaths during recent years.

Obstetrical Death Rate **1.65/1000**

This rate shows a corresponding improvement. It is based on deaths from obstetrical causes only figured against viable deliveries. It represents the true index of the quality of obstetrics practiced, and is a figure for our hospitals to be proud of.

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Dehydration

The preservation of vitamins during dehydration and storage of vegetables is obviously a complex problem. From the strictly nutritional standpoint we rely on the vegetable group as a source of carbohydrate, minerals, vitamin A, and in some cases, protein. Carbohydrate, minerals, and proteins are largely retained during dehydration, but in the case of Vitamin A it would appear that only certain vegetables retain a high proportion during dehydration and storage, and others do not. Much more work is therefore warranted on this specific subject. From a more general standpoint, a liberal quantity and variety of vegetables constitutes a more acceptable dietary for the average American, and hence contributes to the morale of the soldier. At least for the duration of the war, therefore, great emphasis will necessarily be placed on the development of dehydrated vegetables, irrespective of their vitamin contents. — Nutrition Reviews, Vol. 1, No. 13, Nov., 1943.

Why the Otolaryngologist Should be Allergy-Minded

EDWARD KING, M.D.

THERE is evidence to warrant the belief that allergy is becoming more common. Physicians in every field of practice are recognizing the allergic state because allergy is found in all parts of the body. The otolaryngologist must be aware of the conditions in the nose, throat and ear that call for an allergic investigation and he must be prepared to differentiate the cases coming to him for examination and treatment.

To Hansel we are indebted for calling our attention to the part allergy plays in nose and throat diseases. His numerous publications over a period of years have awakened an interest in this subject which should stimulate the otolaryngologist to seek a better understanding of his daily problem.

Sinusitis has long been a carelessly used term. It is employed to describe a set of symptoms which too often have not yielded to measures commonly employed by the rhinologist. Actually, sinus disease is not nearly so widespread as one would be led to believe by the numerous patients who complain of nasal symptoms.

FREQUENCY OF ALLERGY

Excluding acute cold and acute suppurations of the sinuses, the majority of patients who consult the rhinologist complain of headache, more or less nasal obstruction and dripping in the throat. We have made a study of the new patients who came to us complaining of nasal symptoms during six months from January to July, and we have found that 75 per cent of these patients were allergic. During the month of February, 50 per cent of all nasal cases were allergic, and during the month of June, 100 per cent were allergic.

Hansel[1] has made a survey of 200 children who were routine candidates for tonsillectomy and adenoidectomy, and found 13 per cent of these allergic. Recurring colds is one of the chief indications for tonsillectomy, and allergic studies should be made on all patients who have recurring colds, especially children.

The diagnosis and treatment of these patients depends on a thorough examination. The chief complaint and all other complaints should be noted carefully and kept in mind when summing up. The history should include all diseases and especially allergic symptoms, such as eczema in childhood, hives, etc.

In a previous publication, a detailed method of taking a history was described by the author.[2] A smear should be made of the nasal or bronchial secretion and cytologic studies made.

EOSINOPHILES

In allergic cases, a smear will show sometimes pure eosinophilia or large numbers of eosinophiles. The cytologic studies are of great value in the treatment of the case, especially when acute exacerbations occur. It can be determined, as Hansel has shown, whether the acute exacerbation is due to infection or allergy. If infection, such as an acute cold supervenes, the slide will show a predominance of neutrophiles which will be supplanted by the eosinophiles as the infection subsides. Valuable information may be obtained from this procedure.

A thorough examination of the patient is essential. X-rays of the sinuses should be made. It is advisable to correct the badly deviated septum and to remove large polyps when these conditions produce obstruction. At times it may be necessary to clean out the sinus mucosa.

In the majority of cases, however, as has been pointed out above, an allergic study will disclose the cause of the symptoms and proper treatment will bring relief, without resorting to nasal treatment or surgery.

The skin tests are next in order. The common allergens and common foods which are known to produce symptoms most often are tested out intradermally and the reactions noted. In the majority of cases, the common allergens, such as feathers, house dust, orris root, egg, wheat, milk, chocolate, the grasses, ragweed and spores will disclose sufficient information to be of value in the treatment. These patients should be instructed as to environment, such as avoidance of house dust, covering of pillows, etc. Such simple procedures often

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bring startling results. In refractory cases, the diets must be tried and desensitization carried out.

Last year, in conjunction with Dr. J. Harold King,[3] we published a report of cases negative to skin tests and refractory to treatment. I wish to review two of these cases:

Mrs. E. M., housewife, age 27, consulted me in August, 1941, because of nasal obstruction and some sneezing which had been present for one and one-half years, especially in the winter months.

The examination showed a typical allergic nose. Smears showed all eosinophiles. X-rays of the sinuses were negative and all skin tests were negative. The following measures were adopted over a period of four months:

(1) Dust free room
(2) Wheat free diet
(3) Stock vaccine
(4) Torantil
(5) Sulfathiazole
(6) Thyroid extract
(7) Iodized oil in antra
(8) Removal from environment
(9) Ionization of mucosa
(10) Typhoid vaccine
(11) Autogenous vaccine

This patient was completely refractory to the above measures. In January, 1943, in accordance with the recommendation of Hansel,[4] she was called in and examined again. Her symptoms were unchanged. The skin tests showed a slight reaction to house dust. Small doses of house dust were given and she showed the first signs of improvement on 0.40 house dust, 1-10,000. She continued to improve until she was very comfortable within two months with continued house dust injections. The nasal picture changed so that it was possible at her last visit to see the nasal structures without shrinking and she was able to breathe freely. We are continuing small doses of house dust at thirty-day intervals.

Case No. 2: R. N., age 46, consulted me in February, 1941, complaining of nasal obstruction since 1937. Previous to her visit, she had been tested intradermally and had received a great many shots. The nose was completely blocked with large polyps which protruded post-nasally. A smear showed all eosinophiles. X-rays revealed dense clouding of antra and ethmoids, with some clouding of the frontals.

A double radical antrum operation was performed with removal of all mucosa and ethmoid cells. The middle turbinates were removed also.

Allergic studies were made and all skin tests were negative. Very little relief was obtained from surgery. This patient had the following treatments:

(1) Dust free room
(2) Surgery.
(3) Thyroid extract
(4) Stock vaccine
(5) Autogenous vaccine
(6) Ionization, right side
(7) Torantil
(8) Estrogenic substance
(9) Diet

She was completely refractory to treatment. In December, 1942, she was called in and given house dust injections and for the first time, began to show improvement. In May, 1943, after receiving house dust injections for four months, she was able to breathe through the nose for the first time in years. At that time I told her that I would remove some polyps at her next visit. I saw her again in August, 1943, and it was not necessary to remove the polyps. She continues to receive house dust once a week.

Therefore, it is indicated in a good many cases of allergy, where the skin tests are negative, to instruct the patient regarding pillows, mattresses and avoidance of dust and to begin desensitization with small doses of house dust. The histories of these cases as a rule show that they have symptoms during the winter months. The patients as a rule will ascribe the symptoms to a cold or chronic sinus disease. The symptoms begin in the fall and clear up in the spring. This is due to the fact that house dust is more concentrated in the winter months with the windows closed and the furnace going.

SINUS TROUBLE?

Eosinophilia is present in most of these cases unless an acute cold has supervened. X-rays of the sinuses are negative and very often the examination of the nose shows merely a slight bogginess of the mucosa, with very little deviation of the septum and no other signs of disease of the nose or sinuses. These patients, as a rule, complain of dripping in the throat and dull headache, and on being asked their chief complaint, will state that they have sinus trouble. The skin tests by the intradermal technique have been extremely satisfactory because in a large percentage of cases, they have helped to indicate the line of treatment. It is self evident to the trained rhinologist that patients who complain of symptoms in the warm months, i.e., from May to October, are probably sensitive to some of the pollens. Yet it is my experience that the patients fail repeatedly and continuously to receive the proper advice and treatment.

Chronic cough is one of the symptoms which the rhinologist is called upon to solve. After the internist has exhausted every field of investigation, he refers the patient to the rhinologist for an explanation of the cough.

A case recently under my care will illustrate the value of considering allergy, where other investigations are negative:

Miss M. H., age 28, stenographer, complained of cough, beginning in October and continuing through the winter. She coughed constantly in the evening and through the night, so that her sleep was disturbed. This symptom had been present for three or four years and had been growing worse. She had no other complaint and had recently had a thorough physical examination with negative X-rays of the chest. She was referred by her family physician for an investigation of the nose and sinuses. The examination showed the nose and

sinuses clear. The throat and ears were negative. With difficulty, a small amount of secretion was obtained from the nose and the smear showed a few eosinophiles. Skin tests were made and she was found sensitive to feathers, and house dust. Removal of the feather pillow and a few injections of house dust cleared up the cough completely.

Too little attention has been paid to allergy in most of the publications on sinus disease. There is a tendency to describe gross nasal changes, such as a wet membrane or slightly hyperplastic membrane to infection, which required drainage. Very often this theory is substantiated by X-ray findings which disclose cloudiness of ethmoids or antra, or both, without regard for the fact that the allergic membrane may produce some clouding of the X-rays.

It is recognized by allergists and should be understood by the rhinologist that in many patients the allergic symptoms are manifested by hay fever alone over a period of years and then some other allergy follows in the wake of hay fever. In other words, the hay fever symptoms fail to clear up on the disappearance of pollen from the air and the symptoms continue unabated during the cold months. In many cases this is attributed to infection supervening on the allergic background. Much time and effort may be wasted on local treatments.

It should be made plain to all patients who are allergic that there is no treatment for the nose which will solve their problems. An allergic study is the shortest and surest road to a satisfactory solution.

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Vitamin B and Dehydration

Few values are to be found in the literature for the B-vitamin contents of dehydrated vegetables. Moyer's study indicates an average loss of thiamine of 20 to 25 per cent during dehydration processing of cabbage, rutabagas, beets, and potatoes. This is due largely to the leaching action during blanching. Thiamine was stable during storage for a six-month period whether the vegetable was packed in tightly closed glass containers, under carbon dioxide in closed glass containers, or in cellophane or pliofilm bags. Other B-vitamins, with the possible exception of riboflavin, would be expected to withstand the drying process and be stable in a variety of storage conditions.—Nutrition Reviews, Vol. 1, No. 13, Nov., 1943.

Verrucae

Warts are a common complaint. As the chief objection to them is cosmetic, their removal should leave no undesirable cosmetic defect. Removal by means of X-ray is the best method as it is painless and no scar remains.

For purposes of discussion and treatment, warts should be divided into four classes—adolescent warts, warts at the edge of the nails, plantar warts, and common warts not included in the above classes.

Treatment of the warts that occur during adolescence is not justifiable. Usually they are multiple, and to treat them is time-consuming and tedious, so that if the radiologist were to be properly paid for the time and trouble, the cost would be excessive. These warts will all disappear in a few months if left alone, so there is no necessity for treatment.

Warts which grow at the edge of the nail are very difficult to remove by any method. No matter what method is used, at least half of them will recur. The patient should be advised of this before treatment is undertaken, and a good prognosis should not be given. Because of the strong tendency to return, large quantities of radiation are necessary. A mask of lead should be made to fit the wart, and at least 2500 roentgens, measured in air, of unfiltered or lightly filtered long wave-length radiation given at one sitting. This will produce a painful reaction in the large warts, and a moderately painful one in the small. If the wart recurs after this treatment, further irradiation should be applied only if the patient understands the risk of permanent skin damage, or possible permanent damage to the nail.

Plantar warts have more than a cosmetic effect. They frequently cause the patient considerable pain. The treatment of plantar warts is eminently successful by irradiation. All of them can be removed. The normal skin around the wart should be protected, and the wart given 1500 r, measured in air, with unfiltered or lightly filtered long wave-length radiation. A singular and accountable relief of pain follows the treatment within the first twenty-four hours, with no visible change in the wart. During the third week, the wart again becomes painful, due to a moderate irradiation reaction. This requires no treatment, other than padding, if walking is uncomfortable. The painful stage lasts about a week. Between the fourth and sixth week the wart comes out, leaving normal skin. A few of the thicker warts may require a second treatment if they are not gone at the end of six weeks.

Warts of the last class, found usually on the fingers, but not at the nail edge, are treated as are plantar warts, with the same results.—Sydney J. Hawley, M.D., Danville, Pa.; Penn. Med. Jour., Vol. 46, No. 12, Sept., 1943.

The Nutritive Value of Dehydrated Vegetables

The subject of dehydration of foods is under intensive investigation. The rewards, particularly in time of war, are apparent; many foods may be reduced to a fifth or tenth of their fresh weight and volume and hence save greatly in shipping and storage space, and in container materials. It is not a simple problem, however, to provide a dehydrated vegetable which upon rehydration will possess a reasonable degree of original appearance, taste, and nutritive quality. Some of the dehydrated soups offered to the public are palatable, but here the use of flavors and condiments may offset other possible flavor changes occurring during dehydration. Many of the dehydrated vegetables are certainly less desirable from the esthetic standpoint. It is these considerations which are most likely to determine whether dehydrated vegetables will or will not assume a general public use after the war. At the present time it seems unlikely that they will find any great role in home consumption, but they are of immediate importance in the war program and merit intensive study.

Fundamental in the objects of the dehydration program is the question of the preservation of the vitamins which are present in the fresh product. Such factors as the type and extent of blanching before dehydration, the temperature, time and degree of drying, and storage conditions, are prime considerations in attaining a maximum stability of the vitamins. A preview of the work in this field reveals that there are few general principles to follow since each vitamin and even each vegetable presents a different problem. The data with respect to vitamins A and C are commonly in disagreement, but many apparent differences must depend on the different processing conditions employed by various investigators.

Work by Beckley and Notley *(Biochem. J.* 35, *1396 (1941)* on the preservation of ascorbic acid in vegetables indicated that a lower dehydration temperature, even though requiring a longer time, was more favorable. Bruising of the vegetables prior to dehydration was found to yield a product inferior in vitamin C content. It was reported preferable to blanch potatoes and cauliflower before dehydration, while carrots, green beans, and cabbage should be dried without previous blanching. It was also noted that vegetables which were not blanched before dehydration might lose even more vitamin C upon soaking due to reactivity of oxidative enzymes. The vitamin C loss on dehydration, however, was great with all the vegetables, amounting to 70 to 90 per cent and no principle was evolved as to how to preserve this unstable vitamin.

Moyer *(J. Am. Dietet. Assn.* 19, *13 (1943))* has reported results from the New York State Agricultural Experiment Station on the nutritive value of vegetables at different stages of the dehydration process. In the case of Vitamin C it was a general finding that 20 to 30 per cent may be lost during blanching and that a further great loss occurred during the actual drying. Other reports indicate a fair percentage of retention as the result of lower temperature of dehydration (less than 70°C.); nevertheless nearly complete loss occurred during storage. The most recent results confirm earlier conclusions that dried fruits and vegetables are nearly devoid of vitamin C. Even fresh vegetables as commonly prepared, with the exception of tomatoes, cannot be relied upon to furnish any large proportion of the daily vitamin C requirement.

Of all the vitamins, we rely most heavily on vegetables for our source of Vitamin A, mostly in the form of carotene. Here, as in the case of vitamin C, there is present in certain vegetables an enzyme which may destroy the vitamin. The data concerning vitamin A losses during drying are neither complete nor in general agreement. Moyer reached the conclusion that little carotene is lost during the processing of rutabagas prior to dehydration or in the actual drying process. It was not completely stable during storage but the losses could be minimized by storage in an atmosphere of carbon dioxide.

The vitamin A values of dehydrated carrots and sweet potatoes are of particular interest since they are rich sources of carotene. A Puerto Rican variety of sweet potato grown in Texas is now being commercially dehydrated and marketed as "Vita Yam". Earlier results of Fraps and Treichler *(J. Agr. Research* 47, *539 (1933)* indicated considerable loss of vitamin A due to oxidation during the drying process. Scoular and associates *(J. Am. Dietet. Assn.* 19, *428 1943)* noted very little loss of caretone in the sweet potato during drying and only a 17 per cent loss during storage for one year in a metal container at room temperature. Lease and Mitchell *(S. Carolina Agr. Exp. Sta. Bul. No. 329 (1940)* report that the carotene content of raw Puerto Rican sweet potatoe averages 40 micrograms per gram and the flour 130, which with a water content of the fresh product of 68 per cent, indicates no loss of the provitamin during the dehydration process.

The situation appears to be different in the case of carrots since Scoular and associates confirmed earlier work in finding an 80 per cent loss of carotene during drying.—Nutrition Reviews, Vol. 1, No. 13, Nov., 1943.

Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

IN combating the spread of communicable diseases, the isolation of the case throughout the period of marked infectivity is of considerable importance. At best, however, this can be only partially accomplished, for the period of infectivity so often begins hours or days before symptoms sufficiently manifest themselves to make possible a diagnosis. Mild subclinical infections go undiagnosed, yet serve to spread infection to others. Obviously, with such initial gaps in isolation procedure, we can hope to gain but little by being hyper-meticulous in carrying out the latter part of the isolation process. The effort should be two-fold: (a) to prevent, as far as practicable, the spread of infection to others; (b) to keep the time lost by the case in isolation at a minimum.

Measles. Communicable from the onset of the catarrhal symptoms (usually at least three days before the appearance of the rash) until the catarrhal symptoms have ceased (usually shortly after the return of the temperature to normal and well before the rash has completely disappeared). In a case without complications or abnormal discharges, release from isolation is usually safe any time after the fifth day following the appearance of the rash, provided the catarrhal symptoms have ceased.

Mumps. Communicable from 24 hours preceding the appearance of symptoms until the subsidence of all swelling in salivary glands or involved testicles. Release from isolation is usually safe 24 hours after all swellings of salivary glands or testicles have subsided. (It should be remembered, however, that with adult males the chance of orchitis persists for about one week after the subsidence of the parotitis.)

Rubella (German Measles). Apparently communicable from 24 hours preceding the appearance of the rash until the subsidence of the rash. Release from isolation is usually safe 24 hours after the disappearance of the rash.

Scarlet fever, Streptococcic pharyngitis, Streptococcic tonsilitis. Most communicable in the first two weeks of the illness, communicable in the third week in approximately 25 per cent of cases, communicable in the fourth week in approximately 5 per cent of cases, communicable after the fourth week in approximately 1 per cent of cases. Release from isolation is usually safe 21 days after the onset of the disease, provided there are no complications or discharges. For another three weeks after release from isolation the patient should consider his nose and throat secretions still possibly dangerous to others. Desquamation has no relation to communicability.

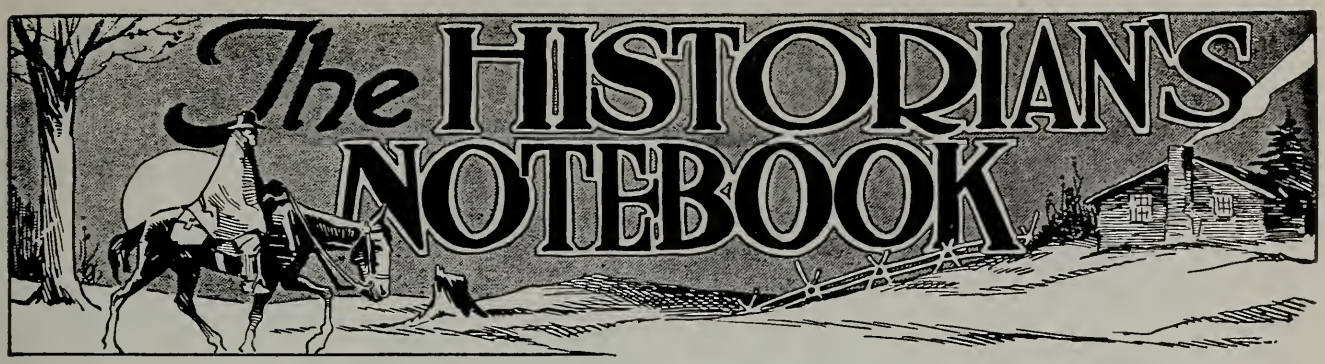
Chickenpox. Infectious from 24 hours preceding the appearance of the eruption until there are no longer any actual pustules. Release from isolation is usually safe when all pustules are gone (usually about seven days from onset), and the patient has taken a thorough bath and shampoo. The dry scabs apparently bear no relation to communicability.

Meningococcus meningitis. Probably communicable throughout the course of the disease and until the meningococci have disappeared from the secretions of the nose and throat. Release from isolation is usually safe when 14 days have elapsed since the onset and the fever has subsided.

Poliomyelitis. Apparently communicable the last one or two days of the incubation period, and for the first seven to ten days of the disease (virus may be found in the stools even much later in the disease). Isolation is necessary only during the first 14 days following onset.

Smallpox. This disease is apparently the most communicable of all diseases. It is communicable from the inception of the first signs or symptoms until the complete disappearance of all crusts and scabs. There is some evidence that the disease is communicable in the last one or two days of the incubation period. Isolation in screened quarters, free from vermin, is necessary until recovery is complete and all crusts and scabs have disappeared.

Diphtheria. Communicable from 24 hours before the onset of symptoms until the diphtheria bacilli have disappeared from the nose, throat or other site of infection. Isolation should be continued until symptoms and discharges have ceased and two successive nose and throat cultures, taken no less than 24 hours apart, are negative. There, however, is one common communicable disease that seldom flaunts a rash, that does not start with a high fever,, that fails to herald its approach by means of sore throat, overwhelming malaise, violent headache or major digestive upset. That disease is tuberculosis, and the time of the year to watch out for it is exactly twelve months long!—BuMed. News Letter, Bureau of Medicine and Surgery, U. S. Navy, Captain W. W. Hall, Editor. (Journal-Lancet, October, 1943).



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

Botanic Medicine in the Western Country

PHILIP D. JORDAN, PH.D.

THE lure of the western country, that magic back-of beyond where men were promised economic security and freedom from the political conservatism of New England and tidewater aristocrats, was tugging at thousands in the year 1800. Common men, weary now that the long and mismanaged War for Independence was over and the new nation relatively safe in the hands of smug bankers and class-conscious cabinet members, emigrated to trans-Alleghany fields and forests. They struggled through Cumberland Gap to settle on the bloody ground of Kentucky and in the Bluegrass region; they poured across Pennsylvania to rendezvous at old Fort Pitt; they piled their flatboats to the gunwales with shelled corn, black powder, betty-lamps, and bullet-moulds and poled or floated up and down a score of rivers—the Monongahela, Kentucky, Wabash, Ohio, Mississippi, and Missouri. Within a century they had swept across the Great American Desert, penetrated the passes of the Rockies, and were impressing the pattern of American ingenuity from Vancouver to Monerey. Their march was marked by rank upon rank of gravestones. And many who lived were scarred by hardship, pestilence, and disease.

The Author

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FRONTIERSMEN

The ailments of the "stalwart" frontiersmen, indeed, were so numerous and the mortality rate so high that had it not been for an excessively heavy birthrate, the progress of western migration might have been considerably retarded. In 1815, Daniel Drake said that the prevailing disease in Cincinnati was pulmonary consumption and listed, in addition, pleurisy, croup, cholera morbus and cholera infantum, colds and catarrhs, swelled tonsils, premature decay of the teeth, rheumatism, remitting and intermitting fevers, including ague, mild and malignant typhus fever, dysentery, jaundice, inflammation of the liver, sore eyes, measles, whooping cough, mumps, smallpox and putrid sore throat, influenza, consumption, typhoid fever, the itch, worms, and goitre.[1] Travelers and adventurers listed more than 70 diseases found in the western country.[2] The Reverend Mr. Robert Baird devoted pages to a discussion of sickness and disease in the Mississippi Valley.[3] Other authors sought to explain why both endemic and epidemic ills swept along the frontier in plague proportions.

It was believed that emigrants became sick because they were unused to exposure, because they lived in damp, uncomfortable houses, and because they were eating new and strange foods.[4] Oliver G. Steele, author of a guidebook which had gone into sixteen editions by 1849, said that "emigrants who clothe and feed themselves properly, keep out of the damp airs of night, and abstain from the use of ardent spirits, may calculate with as much certainty on enjoying good health, as in any of the New England states."[5] Stagnant waters, putrid animals, and vegetables were said also to be among the principal causes of sickness.[6]

MALARIA

As early as 1818, Darby ascribed disease to the bite of the mosquito when he wrote: "The sickness so prevalent amongst American boatmen,

Read before the Miami Men's Club, October 25, 1943.

A TABLE OF MEDICINES WITH THEIR DOSES & QUALITIES ANNEXED

From John C. Gunn, Domestic Medicine, or, Poor Man's Friend. Showing the Diseases of Men, Women and Children, and Expressly Intended for the Benefit of Families. (Madisonville, Tenn., 1834), 601-4.

MEDICINES	ADULTS		FROM 20 TO 15		FROM 15 TO 10		FROM 10 TO 6		FROM 6 TO 4		FROM 4 TO 2		FROM 2 TO 1		UNDER ONE		QUALITIES
	From	To	From	To	From	To	From	To	From	To	From	To	From	To	From	To	
Arsenical Solution	5	12 drops	5	10 drops	4	8 drops	3	6 drops	2	5 drops	1	4 drops	½	3 drops	½	1 drop	Tonic
Antimonial Wine	2	4 drachms	2	3¼ drms.	2	3 drms.	1¼	2½ drms.	1	2 drachms	1	1½ drms.	1	1 1/3 drms.	½	1 drm.	Emetic
Aloes	5	20 grs.	4	18 grs.	3	15 grs.	3	12 grs.	2	10 grs.	2	8 grs.	1	6 grs.	½	5 grs.	Cathartic
Balsam Copaiva	20	80 drops	20	60 drops	15	40 drops	10	30 drops	10	20 drops	8	15 drops	5	10 drops	2	5 drops	Corroborant
Balsam Turlington	20	80 drops	20	60 drops	15	40 drops	do	do	do.	do.	do.	do.	do.	do.	do.	do.	Do.
Bark Peruvian	½	2 drms.	½	1½ drms.	25 gr.	1¼ drms.	20	60 grs.	15	40 grs.	10	30 grs.	8	20 grs.	5	15 grs.	Tonic
Calomel	10	60 grs.	10	40 grs.	10	30 grs.	5	20 grs.	5	15 grs.	5	10 grs.	3	8 grs.	1	5 grs.	Cathartic
Camphor	6	20 grs.	5	15 grs.	3	10 grs.	2	8 grs.	2	4 grs.	1	3 grs.	1	2 grs.	½	1 gr.	Stimulant
Cream of Tartar	½	2 ounces	½	1½ ounces	3	10 drms.	2	8 drms.	2	5 drms.	1	4 drms.	½	2 drms.	½	1 drm.	Aperient
Caustic vol. alk. liq.	½	2 drms.	½	1½ drms.	½	1 drm.	23	30 drops	20	40 drops	15	30 drops	10	20 drops	5	10 drops	Stimulant
Columbo	10	60 grs.	10	30 grs.	10	40 grs.	8	30 grs.	5	25 grs.	5	20 grs.	4	15 grs.	2	10 grs.	Tonic
Chalk prep'd	20	50 grs.	20	40 grs.	15	35 grs.	15	30 grs.	12	30 grs.	10	25 grs.	7	20 grs.	5	15 grs.	Absorbent
Castor Oil	½	3 ounces	½	2½ ounces	½	2 ounces	3	8 drms.	2½	6 drms.	2	5 drms.	1½	4 drms.	1	2 drms.	Purgative
Ess. Pepper Mint	10	60 drops	10	50 drops	8	35 drops	6	20 drops	4	15 drops	3	12 drops	2	10 drops	1	6 drops	Carminative
Elix Vitrol	10	40 drops	10	30 drops	8	25 drops	6	20 drops	5	15 drops	3	42 drops	2	10 drops	1	4 drops	Tonic
Ether Vitriolic	½	2 drms.	½	1¼ drms.	30 ds.	1 drm.	20	60 drops	15	56 drops	10	40 drops	8	30 drops	5	10 drops	Stim. & anti-sps.
Ginger	5	23 grs.	5	20 grs.	4	18 grs.	3	15 grs.	3	12 grs.	2	10 grs.	2	8 grs.	1	6 grs.	Aromatic
Gamboge	5	15 grs.	5	10 grs.	4	10 grs.	3	15 grs.	1	3 grs.							Active Purgative
Hartshorn Spts.	½	1½ drms.	¾	1 drm.	20	30 drops	10	40 drops	10	20 drops	5	10 drops	3	8 drops	2	6 drops	Stimulant
Ipecacuanha	15	30 grs.	15	25 grs.	12	20 grs.	10	15 grs.	8	12 grs.	5	10 grs.	4	8 grs.	1	5 grs.	Emetic
Jalap	5	40 grs.	10	30 grs.	8	23 grs.	5	20 grs.	5	15 grs.	4	12 grs.	3	8 grs.	2	5 grs.	Purgative
Laudanum	20	60 drops	20	50 drops	15	40 drops	10	30 drops	8	20 drops	5	15 drops	3	8 drops	2	6 drops	Anodyne
Magnesia	½	2 drms.	½	1¼ drms.	20	60 grs.	15	45 grs.	12	40 grs.	10	35 grs.	8	25 grs.	5	20 grs.	Absorbent
Manna	1	2 ounces	1	1¼ ounces	1	1 1/3 ounce	½	1 ounce	3	6 drms.	2	4 drms.	1	2 drms.	½	1 drm.	Aperient
Nitre	10	30 grs.	10	25 grs.	8	20 grs.	6	15 grs.	5	12 grs.	2	10 grs.	2	8 grs.	1	4 grs.	Febrifuge & Diu.
Opium	½	3 grs.	½	2 grs.	¼	1 gr.											Anodyne
Paregoric	1	4 drms.	1	3 drms.	1	2 grs.	50	100 drops	30	60 drops	20	50 drops	10	40 drops	2	20 drops	Anodyne
Rheubarb	15	40 grs.	12	35 grs.	10	35 grs.	8	30 grs.	5	25 grs.	4	20 grs.	4	12 grs.	2	10 grs.	Purgative
Steel Dust	5	25 grs.	4	20 grs.	3	15 grs.	2¼	13 grs.	2	10 grs.	1	6 grs.	¼	2 grs.			Tonic
Sugar of Lead	1	5 grs.	1	4 grs.	½	3 grs.	½	2 grs.	½	1½ grs.	¼	1 gr.	⅛	½ gr.			Astringent
Salts Epsom	1	2 ounces	1	2 ounces	3	14 drms.	2	12 drops	2	8 drms.	2	6 drms.	1	4 drms.	1	3 drms.	Purgative
Salt of Tartar	10	25 grs.	10	20 grs.	8	18 grs.	6	15 grs.	4	8 grs.	3	6 grs.	2	4 grs.	1	3 grs.	Absorb. & Febr.
Spts. Lavender	30	100 drops	25	75 drops	20	60 drops	15	50 drops	10	35 drops	5	20 drops	4	15 drops	2	10 drops	Cordial
Sulpher Flour	2	8 drms.	2	6 drms.	1	4 drms.	1	3 drms.	½	2 drms.	20 grs.	1 drm.	10	40 grs.	5	20 grs.	Aperient
Sulphate Quinine	2	8 grs.	2	6 grs.	1	4 grs.	1	3 grs.	½	2 grs.	½	1 gr.	¼	½ gr.	¼	½ gr.	Tonic
Tartar Emetic	3	10 grs.	3	8 grs.	2	6 grs.	2	5 grs.	1½	3 grs.	1	2 grs.	½	1 gr.	¼	1 gr.	Emetic
Tincture of Steel	8	20 drops	8	18 drops	16	15 drops	5	12 drops	4	10 drops	3	8 drops	2	6 drops	1	5 drops	Tonic
Tincture of Foxglove	10	50 drops	10	40 drops	8	30 drops	5	25 drops	4	20 drops	3	15 drops	2	10 drops	1	5 drops	Diuretic
Tinct'e of Catharides	10	50 drops	10	40 drops	8	30 drops	5	25 drops	4	20 drops	3	15 drops	2	10 drops	1	5 drops	Stimulant
Vitriol White	20	60 grs.	20	50 grs.	15	30 grs.	12	25 grs.	6	15 grs.	3	6 grs.	1	3 grs.			Emetic

WEIGHTS AND MEASURES

20 grains, 3 scruples } make { 1 scruple, 1 drachm
8 drachms, 12 ounces } make { 1 ounce, 1 pound
8 pints, 16 fluid oun. } make { 1 gal'n, 1 pint
8 fl'd Drm., 60 drops } make { 1 fl. oz., 1 fl. dr.

has been mostly ascribed to intemperance; that circumstance does, no doubt, superinduce disease; but more destructive, and to which American traders, boatmen, and often families, are too frequently exposed, when upon the Mississippi, and adjacent streams, in spring and summer, is the loss of rest from the sting of the mosqueto. This is an evil easily remedied, and to which those persons who have been long enough in the country to adopt the prudent precautions of the inhabitants, are relieved. A mosqueto curtain, made from the cheapest materials, is part of the equipage of everyone who travels either by land or water, in any part of the Mississippi or Mobile country, from April to November."[7] Only rarely did an enthusiastic writer have the temerity to suggest that the "salubriousness of the climate appears adapted to every constitution".[8] And only a confirmed liar, like Edmund Flagg, could believe that most of the diseases peculiar to the West were induced by imprudence, ignorance, or negligence in nursing.[9]

Whatever may have been the causes for disease—and they were many—the average pioneer was forced by circumstances to be his own physician, midwife, and nurse. He relied primarily upon instructions printed in hundreds of texts devoted to domestic medicine, upon wild and cultivated plants and vegetables, and upon superstition and hearsay. Only in instances involving radical surgery did the average frontiersman call for professional assistance.[10] Even the treatment of incised wounds and gun-shot wounds frequently was handled at home, especially after frontiersmen learned not to dilate the mouth of a gun-shot wound except when imperative.[11]

BARKS AND HERBS

There were many reasons, of course, why the western settler, alone with his family in a miserable cabin on the banks of the Wabash, Skunk, or the Arkansas resorted to botanic medicine. A herbal materia medica flourished in natural state all about him. Bark, roots, flowers, and leaves were available for the man who would be his own physician. "The flora of our country," exclaimed Dr. Waterhouse, "will yet so enlarge and establish her dominion, as to supercede the necessity of all other remedies."[12] Samuel Robinson, medical lecturer in Cincinnati, echoed the same sentiments in the purple passage: "Must we go to Europe to import mineral poisons? Must the wealth of the country be sent abroad to bring amongst us the instruments of death? Must we pay with our substance and our lives, for aching bones and ruined constitutions? No! never! The remedies are here; they are spread over the plains and the mountains in abundance, they surround every cottage and bloom round every cabin over the vast and trackless wilderness."[13] In Kentucky, Dr. Richard Carter, author of one of the most charming volumes in western medical history and a physician who, all too freqently, found it difficult to distinguish truth from falsehood, wrote in verse:[14]

My medicine, though it is simple and plain,
Will give you relief, in both sickness and pain;
Although it in part, does consist of good drugs,
Yet the ballance is made of our barks, roots,
and herb.

Many emigrants endorsed a botanic system of medicine not only because herbs were easy to secure, but also because they feared many of the traditional methods of nineteenth-century medical practice. In general, this methodology centered about excessive purging and puking, the use of mercury, laudanum, and calomel, and, of course, reliance upon phlebotomy or bloodletting with either lancet or leech. Dr. John Esten Cooke of the medical faculty at Transylvania University, one of the really great American schools of medicine during the nineteenth century, habitually prescribed from 10 to 20 grains of calomel as a normal dose and upon one occasion poured a pound of the drug down a patient's throat within a period of 24 hours.[15] In addition, he frequently prescribed a "saturated solution of arsenic" for the cure of malaria.

Large doses, as a matter of fact, were the normal rather than the exceptional. A sojourner in New Orleans when that city was a pesthouse of yellow fever, black vomit, and cholera records that he was given four wine-glasses of castor oil in one day "which required as much resolution as I was master of. . . ."[16] Even David Hosack, one of the great instructors of his day solemnly told his medical students to prescribe as a common cathartic 6 grains of calomel, 15 grains of cream of tarter, and 15 grains of jalap.[17] No doubt he was correct when he said that this prescription would "unlock the whole system". A California fortune seeker, deserted by Lady Luck and ill, was obliged to pay six ounces of gold for an ounce of quinine, calomel, and jalap in proportion which he swallowed down in a single dose.[18] Captain Clark, of the Lewis and Clark expedition into the Louisiana Purchase in 1803, prescribed as a standard dose 30 drops of laudanum, and John Long, interpreter and trader among the Indians, infused a considerable quantity of laudanum into a pint of rum which he gave to an Indian chief. The chief, said Long, "immediately took a hearty draught which soon stupified and lulled him into a profound sleep, in which, I was afterward informed, he remained twelve hours—."[19]

The frontiersman, ignorant in book learning as he may have been, early learned to shun the trained physician who insisted upon heavy doses, and soon there sprang into print witticisms and

songs of satire directed at mercury, laudanum, and calomel. A typical example of this Jacksonian humor tells the story of the sick pioneer whose wife had called a physician.[20]

He turns to the patient's weeping wife,
"Give me clean paper, mam, and knife;
I think your husband will do well,
To take a dose of Calomel."

He then weighs out the fatal grains—
"I think, mam, this will cure the pains—
Once in three hours at sound of bell,
Give him a dose of Calomel."

The man in death begins to groan,
The fatal job for him is done,
His soul is forced to heaven or hell,
A sacrifice to Calomel.

Physicians of my former choice,
Take my counsel, hear my voice,
Be not offended though I tell,
I am not fond of Calomel.

And when I have to decline my breath,
Pray let me die a natural death,
And wish you all a long farewell,
Without a dose of Calomel.

In addition to preferring botanic medicines because they were readily available and because they feared the excessive dosages and bloodletting of regular school physicians, westerners were drawn to a vegetable materia medica because it was cheap. The first medical volume published west of the Alleghanies was written by Peter Smith of the Miami Country and was published at Cincinnati in 1813. It contained a variety of directions for preparing medicine for poor men.[21] But it remained for a New Hampshire botanist to first systematize vegetable practice.

Samuel Thomson was among those who bitterly resented the extravagant doses and the excessive phlebotomy of the orthodox physician. To Thomson, jalap, mercury, arsenic, calomel, and laudanum were rank poisons as, indeed, they are when improperly administered. Therefore, he developed a competitive system which rested upon emesis, enemas, and steam baths. Lobelia and capsicum were his basic medicine, although eventually he was to develop an extensive pharmacopoeia. Six desirable aims were set forth:

1. To cleanse the stomach, overpower the cold, and promote a free perspiration.
2. To retain the internal vital heat of the system and cause a free perspiration.
3. To scour the stomach and bowels.
4. To correct the bile and restore digestion.
5. To strengthen the stomach and bowels and restore weak patients.
6. To remove pain, prevent mortification, and promote natural heat.

Each of these objectives was dependent upon the proper use of botanic remedies and specifics in the form of powders, tinctures, bitters, syrups, drops, salves, salts, ointments, and infusions and decoctions. Thomson finally developed six basic preparations upon which his system of materia medica rested. Most botanic physicians aped these six, although many of them, of course, added to the original list.

One of the best emetics in the botanic pharmacy was the *lobelia inflata* which was found in a variety of soils throughout the United States and which commonly was called "Indian tobacco" by pioneers and settlers who, when chewing it, noticed a burning, pungent sensation followed by giddiness, headache, perhaps a trembling of the body, sickness, and finally vomiting. There is evidence that the Penebscot Indians used the plant and that New England colonials relied upon it in cases of gastritis with infants and termed it "colic weed". For years *lobelia* was considered a specific in the treatment of asthma. Mattson, a botanic physician with a tremendous practice, testified that he found *lobelia* particularly useful in "cough, difficulty of breathing, pains, strictures, palpitation of the heart, and nervous affections".

By 1848 some members of the botanic school, although administering from 10 to 20 grains as a normal dose, were saying that lobelia was a "hazardous remedy, and only adapted, as an emetic, to spasmodic asthma, and to facilitate the reduction of strangulated hernia, for which last purposes it is as useful as tobacco, and safer". Thomson, however, never reached this point of caution. "In regard to the quantity to be given as a dose," he wrote in his nonchalant manner, "it is a matter of less consequence than is generally imagined. The most safe way will be to give the smallest prescribed dose first, then repeat it till it produces the wished for operation." The cumulative effect of repeated small doses frequently was more than any pioneer, botanic physician bargained for!

It will be remembered that Thomson's second principle was to retain the internal vital heat of the system and to cause a free perspiration. To accomplish this he utilized capsicum or the red and black pepper or ginger. Capsicum was believed to be "the purest, most prompt, powerful, and permanent stimulant known" and was relied upon as an "internal and general" remedy in the treatment of inflammations and congestions in fever; as a gargle in the putrid sore throat of scarlet fever; and, mixed with pitch, as a plaster in affections of the spine, hip, liver, lungs, and spleen.

(To be concluded in the March issue)

Nebraska Congressman Attacks Medical Bureaucracy—More Specifically the Wagner Bill—in Recent Address

ON December 7, 1943, the Hon. A. L. Miller, member of the 78th Congress, representing a Nebraska district, addressed the National House of Representatives.

When members of the Congress speak on the floor of the Congress, they do not announce a title for their talks. Had Congressman Miller, who happens to be a doctor of medicine and a good one, needed a title for his remarks, he could very appropriately have adopted the title, "A Medical Bureaucracy?"

Using the Wagner-Murray-Dingell Bill as an example, Dr. Miller pointed out to his colleagues the present trends toward regimentation and concentration of power in a central government at the expense of state and local government and private initiative and enterprise.

The following excerpt from the Congressional Record, setting forth Congressman Miller's remarks and the ensuing dialogue is of interest, not only because of the sound criticisms expressed by the speaker but also because it indicates that the reactions of the people back home are beginning to be felt among the members of Congress:

* * *

Mr. Miller of Nebraska. Mr. Speaker, I have asked for this time today to bring to this House and to the country a few statements which I trust will stimulate the thinking of the Members of the House and the people of the country generally. No speech is worth the effort nor the paper it is written on unless it does stimulate thinking and stirs to action. I expect to address a part of my remarks to S. 1161, the Wagner-Murray bill and a similar bill introduced by Representative Dingell in the House. I shall also speak on the subject of regimentation of which these bills are only an example.

CITES GREAT ADVANCES

The practice of medicine under the free institutions of this country of ours has advanced the healing art until it is the envy of the whole world. In the short space of 150 years it has so improved the health of this Nation that the life expectancy has been nearly doubled. Where it was 35 years it is now 63 years. New technics for treating disease have been developed and new drugs have been discovered. The sulfa drugs and penicillin are just the latest examples. Free men with great minds have founded medical schools and colleges and established laboratories for research. There has been a ceaseless probing and searching of the unknown for the purpose of curing disease. Many of the terrible diseases of the past have been rendered almost harmless. Today twice as many of our wounded now recover than in the last World War.

Under the Wagner-Murray-Dingell bills the Federal Government would set up a political control of the practice of medicine. It would be a step in which not only the physician but the individual would be regimented, pigeonholed, blueprinted and made to do a physical, mental, and ritualistic goose step. The first move in a socialistic government has always been to deal with the health and the welfare of the Nation.

I am sure the motives of the sponsors of these particular measures are entirely honorable and wholly altruistic. The arguments in support of them are plausible and alluring but the adoption of these measures would certainly lead to the erection of another bureaucracy to administer them. The resulting regimentation would first hamper the physician and then break down his morale, his initiative, and his effectiveness. The Director of the Public Health Service would be a czar over physicians. In him would be the power to direct where and when, and finally how to practice his art. Rules and directives would be promulgated in the central office that would progressively put the practice of medicine in a strait jacket. The patient could be told to what physician he must report. If you do not believe this just pay a visit to any Social Security Board and see how those who are compelled to come to it for help are herded around and made to fill out endless forms. The physicians' fingers would be stained with ink instead of iodine.

Mr. Curtis. Will the gentleman yield?

Mr. Miller of Nebraska. I yield to the gentleman from Nebraska.

Mr. Curtis. The gentleman referred to the progress that had been made in the practice of medicine in the last 150 years. How much of that progress, if any, has been made by reason of Government bounty or Government supervision or through subsidizing?

Mr. Miller of Nebraska. The progress in the practice of medicine has been made wholly by individual initiative and enterprise by individuals practicing and ferreting out the causes of disease and putting those things into effect. Progress has been made because there has been little interference by Government.

WOULD STIFLE INITIATIVE

Mr. Curtis. I am utterly opposed to the Wagner bill, but suppose that Congress should enact it and turn the health of everybody in the United States over to the politicians and bureaucrats rather than to the individual's own family physician, can we expect the same amount of progress in the future that we have had in the past?

Mr. Miller of Nebraska. This act would stifle individual initiative, it would stifle the progressive development of the medical profession or of any profession. I will bring that out a little further in my remarks, if the gentleman from Nebraska will permit.

If I am any judge of the feelings of the Amer-

CLIP AND SAVE

Clip and save this article for your Wagner Bill File. You will find it handy for future reference.

ican people I am sure they do not want to see the extension of bureaucracy. They want to recover their right of individual initiative and freedom of enterprise. They are tired of being bossed around by Washington. They certainly want the right when they are sick to select their own physician. One of the most powerful aids the physician has is the confidence his patient has in him. Many times it is more valuable than his most potent medicine. The controls set up under these bills would eventually destroy that precious aid.

And how is this system of socialized medicine to be paid for? The best answer I can give to this question is contained in an editorial appearing in the December 1 issue of the North Platte (Nebr.) Telegraph, written by the editor. It is entitled "A Fraud," and reads as follows:

"One phase of the Wagner-Murray bill now before Congress, to broaden the Social Security Act, of which not too much is said by its supporters, is the cost of the proposal. The old fallacy has been encouraged that a magnanimous government stands ready to 'give' something to the people once the measure is passed. Provisions for medical and hospital care contained in the bill are heavily stressed with the inference that they too will be free.

"Such high-pressure sales tactics are fraudulent. The Government will never give anything away because it can give nothing until it first takes it from the people. If the Wagner bill is made into law, the Government will begin immediately to collect additional billions of dollars in taxes to pay for the 'benefits' it will later hand out. As a doctor recently told a patient: If you earn $200 a month, your (social security) bill will be $12 a month, six times more than is now taken out of your pay check—or $144 a year. Your employer will pay a like amount, which means that your bread, your car, your refrigerator, and everything else you buy would have more hidden taxes wrapped up in it. * * * If you are self-employed, you deduct 7 per cent. * * *

"Every time a deduction is made from the salaries and wages of the people and turned over to Government, the power of the Government over the people grows accordingly."

We might pause here to ask what has become of all the billions of dollars that have been collected in this era of the special planners to meet the obligations of the Government in the matters of retirement pay, old-age pensions, and unemployment benefits that are provided for in the present law. The fact is, this money, collected from employees and their employers alike has been used to pay the current expenses of this extravagant regime. When the time comes to meet the purposes for which it was collected the people will again be taxed to supply it.

QUALITY WOULD BE INFERIOR

Mr. Speaker, we must not foist upon the American people a system of medical practice of inferior quality and at a constantly increasing cost with a huge administrative expansion. The question is: Shall medicine continue to be practiced by men and women scientifically trained and devoted to the relief of suffering humanity and with the freedom to perfect themselves in their art or shall the practice of medicine be taken over by a group of untrained bureaucrats who will use the medical profession as a tool and the sick as clay in molding a huge political machine?

For a number of years now there has been a growing tendency for the Federal Government to take from the States and the people the responsibilities that have heretofore been theirs. By the extension of Federal spending it has brought more and more governmental functions to Washington. During the past decade this tendency has veered in the direction of shepherding the individual from the cradle to the grave. The social planners are busy finding ways to take from the people those responsibilities which they consciously accepted when they set themselves up as freemen. But when the people surrender their responsibilities they soon surrender their rights. We will grant that in an emergency like the present war more power must be given to the Central Government. The way in which this power is now being exercised and the fundamental rights it is taking away from the people is a good example of what they can expect if the present bureaucratic controls are made permanent and expanded. It is impossible to set up a system of medical practice as suggested in the Murray-Wagner-Dingell bill without creating a class of bureaucrats whose selfish interests maintain them in office. They possess the poisonous virus of all bureaucracy, that unquenchable desire for increased power.

There is another side to this picture of regimentation and the "glorious decade" recently referred to by the Chairman of the National Committee of the Democratic Party. On that side can be seen the skyrocketing national debt, the loss of the individual rights and the undermining of the constitutional principles upon which this Nation has advanced in the past.

GROWTH OF BUREAUCRACY

This Murray-Wagner-Dingell bill may well become the war cry of the New Deal politician for a fourth term for the President and his coat-tail riders. In the past 10 years of this "glorious decade" we have seen more regimentation by the New Deal, with the individual being subjugated to the rights of an all powerful bureaucratic regime in Washington. Bureaucracy grows and feeds upon itself. It produces dictators with absolute power and people are reduced to serfdom.

Under this "glorious past 10 years" freemen and women are losing their rights to live their lives under the moderate restraints of our Constitution as they see fit. A new philosophy of government is born, an alien and foreign nation, in which this bureaucratic monster in Washington governs and the citizen has no rights they need observe. Yes; there is a dangerous trend in this past 10 years. Many good things have been accomplished, but if we lose our fundamental rights under our Constitution in gaining these social reforms the cost will be too great.

Before I finish my remarks, Mr. Speaker, I want to bring one more thought for the consideration of the Members. I can best do it by quoting from an article recently written by the Honorable Joseph B. Ely, former Governor of the State of Massachusetts, a Democrat who had the vision to see the road down which his party was traveling. He said:

Under the comparatively simple set-up of the early years of our national life and down to 1933 the interest of the city and State politician in Federal politics was slight because the patronage was slight. * * *

LOCAL PATRONAGE EVILS

When in 1933 the Congress went over in a big way for the prepared program of social legislation, business regulation, agricultural control, and $3,000,000,000 of spending money, the city government became extremely interested in national politics. The favor and patronage of Washington were looked upon with covetous eyes. These measures created the politician's paradise. Here was plenty to give the boys that they would not otherwise get. This combination of local ma-

chine politics and humanitarian measures reached its full power at the Democratic National Convention of 1940, when Kelly of Chicago, Hague of Jersey City, and Flynn of New York sat down in a room in the Blackstone Hotel with the social workers of Hopkins, Ickes, and Perkins to trample underfoot the third-term tradition and renominate the President as leader of the social view-point movement for another 4 years' control of this Government.

Let me repeat, Mr. Speaker, the American people, after this conflict is over, want to get back to freedom of individual initiative and enterprise. Too long have they been living in the narcotic fumes of those who have been smoking the pipe of socialistic ideas. They are beginning to fear they will become addicts to the narcotic and will thereby lose their self-reliance and self-respect.

It may seem a little old fashioned to say we should not be doing things to and for the people which they can do for themselves. But it is sound.

Regardless of the party in power we must weed out of Government the dead, useless bureaus and get back to those tried and tested fundamentals of constitutional government which in the past has made this Nation great. We must decide whether democracy shall survive this war, or whether Government dictatorship in the form of socialism or communism will be substituted.

Mr. Stefan. Will the gentleman yield?

Mr. Miller of Nebraska. I yield to the gentleman from Nebraska.

Mr. Stefan. I want to congratulate the gentleman on the very fine statement he has made. I would also like to apprise the House of the fact that the gentleman from Nebraska (Mr. Miller) who has just concluded a very fine speech is a medical doctor and surgeon of very fine reputation in the State of Nebraska. He not only conducted a great hospital out there but he has traveled and healed the sick in many corners of our State. The gentleman knows whereof he speaks and I believe he brings the sentiments to us in the House of Representatives from the American home as we know it on the prairies of Nebraska.

Mr. Miller of Nebraska. I thank my colleague the gentleman from Nebraska (Mr. Stefan) for his kind remarks about my ability as a physician and surgeon. I sometimes feel that I am a better physician than I am a Member of Congress. I am convinced, however, that if the bureaucratic control of this Nation continues, not only medicine, but all the professions and the people we serve will suffer.

Registration For Nurses Postponed

The Directing Board of the Procurement and Assignment Service issued form 328, dated January 1, to state chairmen for nurses, stating that the national registration of nurses planned for the week of February 7 has been postponed indefinitely, owing to circumstances beyond the control of the War Manpower Commission. States are requested not to hold a registration of their own until the status of the national registration is determined. It was also stated that a draft of nurses for military service is not contemplated.

Don't Miss Industrial Health Meeting in Your Area Second Week in February

"Industrial Health and the Doctor", is the theme of the meetings being sponsored during the second week of February by the Ohio State Medical Association and the State Department of Health, to which all members of the Association have received invitations.

Following are the date and place of each meeting:

February 7, Toledo, Toledo Academy of Medicine Auditorium.

February 8, Cleveland, Hotel Cleveland.

February 9, Columbus, Deshler-Wallick Hotel.

February 10, Cincinnati, Netherland Plaza Hotel.

The meetings will begin with an afternoon session beginning at 4 o'clock and concluding at 6 o'clock, with an hour and 45 minutes recess for dinner. No organized dinner will be arranged. The evening session will be from 7:45 to 9:45.

Three outstanding guest speakers of national reputation in the field of industrial medicine will address the conferences. They are: Dr. Carey P. McCord, medical director, Industrial Health Conservancy Laboratories, Detroit; Dr. Rutherford T. Johnstone, director, Department of Occupational Diseases, Golden State Hospital, Los Angeles; and Dr. Frank F. Tallman, director of mental hygiene, Michigan State Hospital Commission, Lansing.

One hour of the afternoon session will be devoted to short informal discussions of local industrial health problems by selected speakers from local industrial health committees, The Council and Committee on Industrial Health of the State Association, and officials of the State Industrial Commission and the State Department of Health.

For complete details, see the invitation and program which you received by mail, and plan to attend one of the meetings. The individual physician has an important responsibility and obligation in the field of industrial health. Attendance at one of the meetings will aid him to better meet that responsibility and obligation.

Urological Essay Award

The American Urological Association offers an annual award not to exceed $500 for an essay (or essays) on the result of some specific clinical or laboratory research in urology. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 15, 1944.

Members Would Be Wise To Make Hotel Reservations Now For Annual Meeting, May 2, 3 and 4, Columbus

IT isn't too early to make your request for hotel reservations for the Ninety-Eighth Annual Meeting of the Ohio State Medical Association, Tuesday, Wednesday and Thursday, May 2, 3 and 4, at the Neil House, Columbus. You know about what type of accommodations you will require. In order to obtain those accommodations, send in your request for reservations at once to the hotel where you wish to stay.

Requests for hotel reservations should be addressed directly to the management of the hotel selected.

Look over the accompanying list of Columbus hotels, their locations and rates. Make your choice. Fill in the blank accordingly, and mail it **NOW**.

NAME AND LOCATION	No. of Rooms	Single	Double	Double Twin Beds	Suites
NEIL HOUSE (Headquarters Hotel) 35 South High St.	665	$4.50-7.00	$5.50-9.00	$6.50-11.00	Rates on request
DESHLER-WALLICK Broad and High Sts.	1000	3.50-8.80	5.50-11.00	6.50-13.30	$8.80 to $26.40
FORT HAYES 31 W. Spring St.	350	3.00 and up	4.50 and up	5.00 and up	7.00-18.00
CHITTENDEN High and Spring Sts.	275	2.50-3.00	3.00-4.00	3.50-6.00	
SENECA 361 E. Broad St.	250	2.50-3.50	3.75-5.00	5.00-5.50	3.75 to 8.00 (single) 5.50 to 10.00 (double)
SOUTHERN High and Main Sts.	250	2.50-3.00	3.50-4.50	4.00-4.50	
VIRGINIA Third and Gay Sts.	150	2.20 and up	3.30 and up	4.40 and up	
BROAD-LINCOLN 631 E. Broad St.	140	2.00 and up plus 10%	3.00 and up plus 10%	4.50 and up plus 10%	3.50 and up plus 10%

HOTEL RESERVATION BLANK

Mail this coupon to hotel selected

Manager_____ Hotel, Columbus, Ohio.

You are requested to reserve the following accommodations during the period of the Ninety-Eighth Annual Meeting of the Ohio State Medical Association, May 2, 3 and 4, 1944, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double room with bath Price:_____

☐ Twin Bed Room with bath ☐ Suite

Arriving May_____ at_____ A.M._____ P.M.

PLEASE VERIFY MY RESERVATION.

Name _____

Address _____

_____

Military Roster Increased by 45 During Past Month; Ohio Physicians Now on Active Duty Total 2722

BASED on information received from official sources or from County Society secretaries, the names of 45 additional Ohio physicians were added during the past month to the military roster maintained by the Ohio State Medical Association. The total number of Ohio physicians on duty as medical officers as of January 21 was 2722, divided as follows: Army, 2325; Navy, 331; other services, 66. During the past month, six Ohio physicians were separated from the services. Those whose names were added to the military roster, those promoted, and the tabulation by counties, follow:

NAMES ADDED TO MILITARY ROSTER

Name	City	Rank
Batten, Grover H.	Cincinnati	1st Lt., U.S.A.
Beltz, Robert V.	Columbus	1st Lt., U.S.A.
Berg, Robert Wm.	Cleveland	1st Lt., U.S.A.
Besst, Stacey A.	Lakewood	1st Lt., U.S.A.
Brickley, Daniel W., Jr.	Marion	Capt., U.S.A.
Bromley, Harry Howard	Shaker Heights	1st Lt., U.S.A.
Brown, Joseph E.	Cleveland	Lt. (j.g.), U.S.N.
Campbell, John	Cincinnati	1st Lt., U.S.A.
Chirelli, G. D.	Youngstown	1st Lt., U.S.A.
Chrispin, John W., Jr.	Dayton	1st Lt., U.S.A.
Clapp, Hubert	Cleveland	Lt. (j.g.), U.S.A.
Cooper, Jack R.	Dayton	1st Lt., U.S.A.
Crawley, Clarence R.	Mount Healthy	1st Lt., U.S.A.
Dana, George W.	Cincinnati	1st Lt., U.S.A.
Diamond, Adrian	Cincinnati	1st Lt., U.S.A.
Frolkis, Nathan P.	Akron	1st Lt., U.S.A.
Gulmi, Peter	Cleveland	1st Lt., U.S.A.
Hamilton, G. Richard	East Cleveland	Lt. (j.g.), U.S.N.
Heaver, Robert J.	Youngstown	1st Lt., U.S.A.
Hensel, Hubert A.	Akron	Lt. (j.g.), U.S.N.
Heppl, John A.	Shaker Heights	1st Lt., U.S.A.
Hyman, Morris	Cincinnati	Capt., U.S.A.
Kennedy, Kendall O.	Delaware	1st Lt., U.S.A.
Kravitz, Hillard L.	Cincinnati	1st Lt., U.S.A.
Loeb, Robert D.	Columbus	1st Lt., U.S.A.
Mansfield, Geo. H.	Akron	1st Lt., U.S.A.
McGarvey, C. J.	Shaker Heights	1st Lt., U.S.A.
Metz, Geo. W.	Cleveland	1st Lt., U.S.A.
Miglets, Andrew W.	Youngstown	Passed Asst. Surg. (R), U.S.P.H.S.
Mignerey, Harry P.	Toledo	1st Lt., U.S.A.
Otis, John	Lakewood	1st Lt., U.S.A.
Petter, John B.	Cleveland	1st Lt., U.S.A.
Pollex, James H.	Toledo	1st Lt., U.S.A.
Renz, Andrew	Cincinnati	Lt. Comdr., U.S.N.
Sanker, John F.	Cincinnati	Asst. Surg., U.S.P.H.S.
Schneble, R. C.	Dayton	Lt. (j.g.), U.S.N.
Schroeder, Edmund	Cleveland	1st Lt., U.S.A.
Shannon, William	Cincinnati	Capt., U.S.A.
Staton, Harvey J.	West Carrollton	1st Lt., U.S.A.
Steves, Mervin F.	Cincinnati	Spec. Consultant, U.S.P.H.S.
Storer, Wm. E.	Middletown	1st Lt., U.S.A.
Thompson, Nicholas J.	Cincinnati	1st Lt., U.S.A.
Ward, George J.	Cleveland	1st Lt., U.S.A.
Weiss, Andrew J.	Cincinnati	Lt., U.S.N.
Whitehead, Randolph P.	Toledo	1st Lt., U.S.A.

WIN PROMOTIONS

Name	City	Rank
Anagnost, Basil D.	Toledo	Capt., U.S.A.
Andrews, Stanley B.	Toledo	Capt., U.S.A.
Berlesky, Harry S.	Barberton	Capt., U.S.A.
Blinn, John C.	New Philadelphia	Lt. Col., U.S.A.
Bliss, Theodore L.	Akron	Lt. Col., U.S.A.
Brooks, L. H.	Cleveland	Capt., U.S.A.
Brown, W. H.	Bowling Green	Capt., U.S.A.
Brown, Wilbur Max	Mansfield	Lt. Col., U.S.A.
Cassaday, Charles E.	Columbus	Capt., U.S.A.
Cellio, Lewis W.	Carrollton	Lt. Col., U.S.A.
Chudde, Sam S.	Dayton	Capt., U.S.A.
Curtzwiler, Francis C.	Toledo	Major, U.S.A.
Donath, Stephen	Toledo	Capt., U.S.A.
Dutton, A. S.	Put-In-Bay	Major, U.S.A.
Falk, John H.	Cincinnati	Capt., U.S.A.
Forrester, C. R.	Toledo	Lt. Comdr., U.S.N.
Forward, Donald D.	Ashtabula	Major, U.S.A.
Garrett, Wm. M.	Frankfort	Capt., U.S.A.
Gillen, John Langdon	Canton	Major., U.S.A.
Greenfield, Jack	Cleveland	Capt., U.S.A.
Horger, Wm. J.	East Liverpool	Major, U.S.A.
Hulse, Charles A.	Cleveland	Major, U.S.A.
Kramer, John A.	Ada	Capt., U.S.A.
Johnson, Walter A.	Rossford	Capt., U.S.A.
Johnston, A. M.	Marysville	Lt. Col., U.S.A.
Layman, O. L.	Franklin	Capt., U.S.A.
Markey, Leo R.	Cleveland	Lt. Col., U.S.A.
Marlowe, C. R.	Toledo	Capt., U.S.A.
McCarthy, J. E.	Cincinnati	Lt. Col., U.S.A.
Miller, Thomas S.	Maumee	Capt., U.S.A.
Molle, S. Albert	Toledo	Capt., U.S.A.
Musser, Howard O.	Akron	Lt., U.S.N.
Neal, Wm. J.	Archbold	Capt., U.S.A.
Northrup, Spencer	Toledo	Lt. Comdr., U.S.N.
Perry, W. H.	Cleveland	Comdr., U.S.N.
Porbe, Clarence O.	Cleveland	Capt., U.S.A.
Potter, F. A.	Toledo	Major, U.S.A.
Preston, Wm.	Toledo	Capt., U.S.A.
Purchla, E. J.	Toledo	Capt., U.S.A.
Radecki, Joseph A.	Toledo	Capt., U.S.A.
Rayman, Lawrence	Toledo	Capt., U.S.A.
Read, John T.	Columbus	Capt., U.S.A.
Rehm, Ernest D.	Toledo	Capt., U.S.A.
Rossmiller, Harold R.	Cleveland	Major, U.S.A.
Roth, Albert E.	Wooster	Major, U.S.A.
Sadugor, Marvin	Cleveland	Major, U.S.A.
Schlueter, S. A.	Akron	Lt. Col., U.S.A.
Scheetz, M. E.	Kalida	Capt., U.S.A.
Shroder, L. N.	Greenville	Capt., U.S.A.
Scott, R. P.	Norwalk	Capt., U.S.A.
Smead, Robert L.	Toledo	Capt., U.S.A.
Smith, Merl B.	Toledo	Capt., U.S.A.
Start, Gwyn H.	Toledo	Capt., U.S.A.
Thompson, John M.	Upper Sandusky	Capt., U.S.A.
Urban, John P.	Columbus	Capt., U.S.A.
Werner, Marshall R.	Akron	Capt., U.S.A.
Wertheimer, Jerome I.	Painesville	Capt., U.S.A.
Wherley, Harold F.	Coshocton	Major, U.S.A.
Whitacre, J. F.	Toledo	Capt., U.S.A.
Wirtz, Robert E.	Canton	Capt., U.S.A.

TABULATION BY COUNTIES

Adams	2	Guernsey	6	Muskingum	9
Allen	38	Hamilton	410	Noble	1
Ashland	10	Hancock	13	Ottawa	9
Ashtabula	17	Hardin	7	Paulding	2
Athens	12	Harrison	4	Perry	4
Auglaize	6	Henry	2	Pickaway	5
Belmont	12	Highland	8	Pike	2
Brown	4	Hocking	4	Portage	2
Butler	29	Holmes	2	Preble	7
Carroll	1	Huron	15	Putnam	6
Champaign	8	Jackson	1	Richland	38
Clark	31	Jefferson	30	Ross	24
Clermont	9	Knox	11	Sandusky	11
Clinton	7	Lake	18	Scioto	19
Columbiana	11	Lawrence	7	Seneca	12
Coshocton	4	Licking	17	Shelby	7
Crawford	9	Logan	8	Stark	97
Cuyahoga	665	Lorain	36	Summit	145
Darke	6	Lucas	152	Trumbull	28
Defiance	4	Madison	6	Tuscarawas	19
Delaware	7	Mahoning	111	Union	[illegible]
Erie	9	Marion	15	Van Wert	9
Fairfield	9	Medina	13	Vinton	2
Fayette	2	Meigs	3	Warren	4
Franklin	220	Mercer	6	Washington	7
Fulton	6	Miami	13	Wayne	13
Gallia	4	Monroe	1	Williams	8
Geauga	4	Montgomery	135	Wood	17
Greene	7	Morgan	3	Wyandot	3
Total					2722

Areas Which Could Use a Civilian Physician, Ineligible for Military Service, Are Listed by Committee

THE Ohio Procurement and Assignment Committee for Physicians has asked the cooperation of *The Journal* on the matter of publicizing the names of areas where the services of a physician licensed in Ohio and ineligible for military service because of age or physical disability, could be utilized.

One of the primary functions of the committee is to assist a community in interesting some physician ineligible for military service to locate there as a replacement for some younger physician who has entered military service or to alleviate a shortage due to the illness or death of a civilian practitioner.

The need of the armed forces for medical officers has been great and still exists. This need must be met. At the same time, the committee feels obligated to give proper publicity to areas which have sent younger doctors to the military forces and are in need of physicians ineligible for military duty to serve civilians for the duration.

NO RECOMMENDATIONS MADE

The Procurement and Assignment Committee makes no specific recommendations to any physician that he locate in a certain area nor does it recommend any particular area to a physician willing to relocate. Physicians who may be interested in relocating should investigate the situation at areas which are listed below. They should confer with physicians in the county, especially the officials of the County Medical Society, and prominent citizens of the area when making their investigations.

Dr. Robert Conard, chairman of the committee, points out that the situation in the places listed is in no sense of the word acute but that the committee feels that the likelihood of an emergency developing would be obviated if another civilian physician were to open a practice in such areas. Dr. Conard stated that some of the communities listed have active physicians at this time but that they are carrying a heavy load and would no doubt welcome the assistance of another competent practitioner.

Physicians ineligible for military service who are interested in relocating or are willing to engage in civilian practice in some area needing physicians, as a patriotic act and as a part of the war effort, should investigate the opportunities in the following communities listed by the Procurement and Assignment Committee:

LIST OF COMMUNITIES

East Fultonham, Muskingum County—Population 800; estimated population of area to be served, 2,200; farming and small industrial community.

West Carrollton, Montgomery County—Population 2,100; near Dayton but in need of civilian resident physician.

Oak Hill, Jackson County—Population 1,619; rural area surrounding of substantial population.

Lynchburg, Highland County—Population of town and surrounding territory, 3,000; rural community.

Etna, Licking County—Population 300 but substantial rural population in area; between Columbus and Newark.

Irondale, Jefferson County—Population 1,676; in addition substantial rural and mining population in area.

Grafton, Lorain County—Population 971; large rural area.

Bridgeport, Belmont County—Population 4,835; in addition, rural and mining population.

Bergholz, Jefferson County—Population 1,200; mining and rural area.

Bradford, Darke County—Population 1,775; rural area in addition.

Cleves, Hamilton County—Population 4,000; rural and industrial area.

Ft. Loramie, Shelby County—Population 507; substantial rural population in addition.

Germantown, Montgomery County—Population of town and area, 4,000; near Dayton but can use resident civilian physician.

Manchester, Adams County—Population, 2,163; rural area.

Peebles, Adams County—Population 1,356; rural area.

St. Paris, Champaign County—Population 1,308; rural area.

Strongsville, Cuyahoga County — Population 2,216; near Cleveland but outlying area in need of resident civilian physician.

Sardinia and Mt. Orab, Brown County—Villages in rural area.

Miss Haney Retires After 30 Years of Service For State Association

Miss Alice Haney, who had been a member of the Headquarters Office staff of the Ohio State Medical Association for approximately 30 years, retired on January 1.

During her long and faithful service with the State Association, Miss Haney had served as assistant to the Editor of *The Journal* and the former Publication Committee, as Membership Secretary, and as bookkeeper.

Most of Miss Haney's work will be carried on by Miss Florence Okert, who has been associated with the Columbus office staff in a secretarial capacity since 1936.

Suggestions for Physicians Relative to U. S. Income Tax Law Deductions, Procedures, Forms and Payments

DUE to the complexity of the Current Federal Income Tax Act of 1943, the wide variance of its application in individual cases and the uncertainty as to the provisions and rates of the Income Tax Law for 1944 now pending in the Congress, it is impractical for *The Journal* to follow its usual custom of publishing a complete and detailed income tax story for the guidance of physicians in filling out their return and computing the tax.

The accompanying article is confined to some of the high spots of the law, with an explanation of the items which physicians in private practice can properly deduct as business expense from gross income.

The Journal urges every physician to seek advice and assistance from competent legal or tax authorities or staff members in the offices of the District Collectors of Internal Revenue. Because of the high rates and possible penalties involved, it is most important that every physician prepare his income tax return accurately and carefully.

BLANKS AND PAYMENTS

On or before March 15, 1944, every physician who comes within the provisions of the Income Tax Law, must do the following:

1. File an actual return, on Form 1040, for 1943.

2. Pay the difference, if any, between the income tax he paid during 1943 based on the estimated return for 1943 which he filed on or before September 15, 1943, and the amount of the tax computed on his final return for 1943 filed on or before March 15, 1944. If he has overpaid, the excess amount will be refunded or credited against future tax payments.

3. Pay one-half of the unforgiven 25 per cent portion of his 1942 or 1943 tax, whichever is lower, the balance payable on March 15, 1945. He may pay the entire amount on March 15, 1944, if he elects to do so.

4. File a declaration of estimated tax for the year 1944, and pay one-fourth of the estimated tax for 1944, the balance payable quarterly thereafter. Blanks for filing the 1944 return presumably will be mailed to taxpayers of record after passage of the Income Tax Act of 1944 now being considered by Congress.

NO REPORT ON SALARIES, WAGES REQUIRED

In previous years it has been necessary for every person making payments of salaries, wages, interest, rents, commissions or other fixed or determinable income of $500 or more during the year to a single person, a partnership or a fiduciary, or $1,200 or more to a married person, to make a return of such payments on Forms 1096 and 1099.

It will not be necessary this year to report salaries of office assistants and other employees who are subject to the withholding tax, but other payments such as rent, if they come within the limits mentioned heretofore and if paid to an individual, must be reported.

Such returns covering the calendar year 1943 must be forwarded to the Commissioner of Internal Revenue, Sorting Section, Washington, D. C., in time to be received not later than February 15, 1944.

DISTRICT OFFICES AND DISTRICTS

Income tax payments and returns must be made at the office of the District Collector of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Collector of Internal Revenue Harry F. Busey, Federal Building, Water and Gay Sts., Columbus, comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Collector of Internal Revenue Thomas M. Carey, 262 Federal Building, Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Collector of Internal Revenue Thomas A. Gallagher, Customs Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Acting Collector of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Darke, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot

THOSE IN MILITARY SERVICE

A physician who is on active military duty should file his income tax return in the office of the Collector of Internal Revenue of the district in which he was a legal resident im-

'mediately prior to his entrance into active service. Compensation received for military service is subject to income tax.

Members of the armed forces who are on duty outside the continental limits of the United States are not required to file a return until the 15th day of the third month following their return to this country.

Men in the service are permitted a deduction of $1,500 from gross income, in addition to the usual personal exemption and the credit for dependents.

DEDUCTIBLE ITEMS

In computing net income, the following items may be deducted by a physican from gross income:

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he **can not** claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Loss on an automobile used in professional business through depreciation may be deducted. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness. If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business the deductible depreciation should be computed on the basis of the amount of time the car is used for professional purposes. If a physician possesses two cars, each of which is used partly in professional business, the deductible depreciation on each car should be computed on the basis of the amount of time each car is used for professional purposes. In other words, if an automobile is used only partly for business purposes, depreciation may be deducted only on a proportionate part thereof, the amount of depreciation depending on the amount of time the machine is used in professional business.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted. Expenses incurred in taking graduate courses have been held **not** to be deductible.

Traveling Expenses—Traveling expenses necessarily incurred by a physician on professional calls and in **attending medical conventions for a professional purpose** are deductible from gross income.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicines, Supplies, Etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals, and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Equipment, Furniture, Library, Etc.—Cost of surgical instruments and laboratory appliances of more or less permanent value may not be deducted but a percentage of the purchase price may be deducted annually under a depreciation account. The same rule applies to office furniture and books purchased for the physician's office library. If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be

good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (where expense is actually incurred and payable even though not yet paid, or income earned although not yet collected) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using this latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—All state and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer upon his interest as shareholders of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible.

Sales tax payments may be deducted. A reasonable allowance will be permitted in proportion to the physician's income. Should the claimed exemption appear too large, however, the burden of proof falls upon the taxpayer, and **he may be called upon to produce purchase receipts to substantiate his claim.** Sales tax coupons **are not** considered sufficient evidence.

The Ohio Gasoline Tax is deductible to the extent of three cents per gallon. If a physician has already deducted the cost of gasoline used in making professional calls as automobile expense, he can not of course make an additional deduction of three cents per gallon for gasoline so used. However, he may deduct that amount on gasoline purchased for other than professional use.

All license fees which the physician is required to pay are deductible, including the narcotic tax, automobile license tag fee, local occupational taxes, taxes on club dues, etc.

All Federal taxes except income, war-profit and excess-profit taxes are deductible, including Federal excise taxes collected direct from the consumer or purchaser.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible on returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. However, Federal Old Age Benefits payroll deductions from employees' wages are not proper deductions from individual Federal income tax returns. The reason for this latter distinction is that the individual employee at a future date will have returned to him in the form of pensions the money which is deducted from his current wages.

Interest—Amounts paid out as interest upon indebtedness (except interest paid to carry nontaxable securities) are deductible.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair and the cost of the repair is claimed as a deduction.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is **not** deductible.

Contributions, Gifts, Etc.—It is permissible to deduct from gross income contributions made to charitable, religious, educational and scientific organizations, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, to an aggregate amount not to exceed 15 per cent of the net income, exclusive of such contributions.

Medical and Dental Expenses—Deduction is permitted for extraordinary medical-dental expenses paid during the year, not compensated for by insurance or otherwise, which are in excess of 5 per cent of the taxpayer's net income. In the case of a husband and wife the expenses are not deductible unless they exceed 5 per cent of the aggregate net income of both. The maximum allowable deduction on a joint return or the return of a head of a family is $2,500, and for a single person, $1,250. The term "medical care" as used in the act, is broadly defined to "include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurance)."

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and the amount. It should be noted that this will furnish the Internal Revenue Depart-

ment with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully.

Ohio Personal Property Tax

Returns under the Ohio Personal Property Tax Law must be made between February 15 and March 31, annually.

All tangible and intangible personal property (not real property) in possession of a physician on January 1, 1944, which is subject to taxation under the Ohio law, should be listed on the return which should be filed with the county auditor between those dates. Form 910 is used by individuals and partnerships, and Form 930 by corporations.

Such returns should be made in duplicate. The so-called intangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar and which involves the computation of accounts receivable.

As defined in Section 5327 of the law, credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments".

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced".

As the first step in making his return under the section relating to credits, a physician should estimate by his best judgment the **Actual Value** of his current accounts receivable—the amount that probably can be collected.

In listing his current accounts receivable, the physician should note after each account what he considers the value of the account. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise, it should be listed at 75%, 50%, 25%, 10%, etc., of its full face value, or of "no value" in case that is considered the "actual value" of the account. The total of these estimates is the total to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts since in his 1943 return he would be permitted to return as of "no value" accounts receivable which he listed in 1942 but no part of which was collected during the past year. Moreover, it permits a physician to depreciate the actual value of accounts returned in 1942 but which have decreased in actual value during the past year.

Old Age Benefits Tax

The Old Age Benefits Tax is payable by every physician who employs one or more persons in his office. It amounts to one per cent on the first $3,000 of each employee's wage paid by the employer and a like amount deducted from the wages of each employee. The tax return and informational return, combined in one report, Form SS-1-A is to be filed **quarterly.** The tax must be paid and the return filed prior to April 30, 1944, for the months of January, February and March, 1944, in the office of the District Collector of Internal Revenue, and quarterly thereafter.

Unemployment Compensation Tax

Under the Ohio Unemployment Compensation Law, physicians who employ three or more persons must file an "Employer's Contribution, Form UCO-2-e, Report," and Form BUC-75, report of individual worker's wages, **quarterly** with the Ohio Bureau of Unemployment Compensation, Columbus. Report for the period of October 1 to December 31, 1943, was due January 31, 1944. The tax, which must accompany the return, amounts to 2.7 per cent of the quarterly payroll, unless qualified for a modified rating.

Employers of eight or more persons, under the Federal Unemployment Compensation Law, must have filed with the District Collector of Internal Revenue on Form No. 940, prior to January 31, 1944, a report of wages paid during 1943. The tax is 3 per cent, less a credit of the amount paid to the Ohio Bureau of Unemployment Compensation. In other words, 90 per cent of the Unemployment Compensation Tax of employers of eight or more persons will be paid to the State and 10 per cent to the Federal Government.

Ohio Use Tax

The Ohio Use Tax Law, passed in 1936 supplementing the Retail Sales Tax Law, imposes a tax on the same basis as the sales tax, on purchases made outside the state. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the State Tax Commission to add the amount of the tax to invoices covering purchases by Ohio consumers, collecting the tax and paying it directly to the Commission. **However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Commission, he is required to report such purchases to the Tax Commission and pay the tax. Returns must be filed with the Commission by April 15, 1944, for purchases during that period January 1 to March 31, 1944, and quarterly thereafter.**

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

DOCTOR, YOUR HELP NEEDED IN FOURTH WAR LOAN DRIVE!

The Treasury Department has made a special request of organized medicine that it take an active part in the Fourth War Loan campaign now under way.

It is hoped that all County Medical Societies and all Ohio physicians as individuals will comply 100 per cent with this special appeal.

A special bulletin has been transmitted to the Secretary of each County Medical Society on this question. Each society has been asked to form a special committee or assign a standing committee to work with local War Bond Committees and to head up the work of soliciting all local physicians during the present campaign.

The medical profession of Ohio is proud of the outstanding record which has been made by Ohio physicians—those of the entire nation as well—during the War. Approximately 3,000 Ohio physicians are in active service—more than one out of every three physicians in active practice prior to mobilization.

While these hundreds of Ohio physicians are serving at great sacrifice and personal risk on the "firing line", those back home are obligated to do everything possible to keep medical and health services functioning for the civilian population. This they are doing in marvelous fashion. Also, they are obligated to make contributions, financially and otherwise, which will provide the tools for those in the services and hasten the end of the war. A sacrifice of time and of money is not an unreasonable request.

Let's demonstrate how we feel and what we can do by rolling up our sleeves and helping to push the Fourth War Loan drive over the top not only through committee activity but by purchasing War Bonds as well!

LEGION'S POLICY APPLIES TO THE WAGNER BILL

We've been asked the question on several occasions: "What is the attitude of the American Legion with respect to the Wagner-Murray-Dingell Bill?" It's a good question as the Legion as well as all veterans' organizations are going to be increasingly potent factors in social, economic, legislative and political affairs in the immediate future and the post-war era.

So far as we have been able to find out the American Legion has taken no action naming specifically the Wagner Bill. But, at the last Legion convention at Omaha, it voted the following language into the record:

"* * * We affirm our fidelity to the basic concept of the American System, a sovereign Federal Government of sovereign states. Freedom of enterprise is of importance equal to the four freedoms of the Atlantic Charter. Extraordinary controls surrendered to the central government should be promptly returned to the States upon termination of the war. These principles we regard as essential to the preservation of the American way of life. To them we hereby dedicate ourselves unreservedly, and we highly resolve to work and fight to preserve on the home front the cherished institutions of liberty and individual freedom, that our soldiers may return from far-flung battle fronts to find the institutions for which they fought, unimpaired."

Enactment of the Wagner Bill would mean the destruction of one of the great segments of private enterprise; of liberty; of freedom; and the permanent concentration of gigantic power in the central government at Washington.

The Wagner Bill is a direct violation of the affirmation of the Legion. It is hoped that other organizations of similar importance will take a similar stand.

FOLDER APPROVED; NOW'S THE TIME FOR ACTION

In a recent issue of the *Industrial Health Bulletin* of the Council on Industrial Health of the American Medical Assocation, the following reference was made concerning the folder, "Fundamentals in the Organization and Operation of an Industrial Health Program by a County Medical Society," issued by the Committee on Industrial Health of the Ohio State Medical Association:

"Not only is this a monumental piece of work by a State Committee on Industrial Health, but it also re-emphasizes the need for local or county medical leadership and activity. Few states have recognized this necessity and attempted to institute local programs."

Before we get puffed up about the kind words of the A. M. A. Council with respect to the State Association's folder, let's remember that the folder is just a small beginning and that so far only a few counties have actually done very much locally. The State Association committee has blazed the way. Now it is up to each County Medical Society to see that something is done locally. A lot will depend on the calibre of the

men selected for the local Industrial Health Committee. It's high time the medical profession in all counties got busy on this matter of setting up an industrial health program. Members of the State Association committee and of The Council are ready to help in any county when their assistance and advice is sought.

GOSH! AND IT HAD TO BE A CONGRESSMAN

Following is an excerpt from the Congressional Record of December 15:

"Mr. Gross. Mr. Speaker, I ask unanimous consent to address the House for 1 minute.

"Mr. Speaker. Is there objection to the request of the gentleman from Pennsylvania?

"There was no objection.

"Mr. Gross. Mr. Speaker, for some time the matter of socialized medicine has been a matter of Nation-wide discussion. I have always opposed it and shall continue to oppose it, but I want to say here and now that if the medical profession of this country do not want their profession socialized they had better clean house of the racketeers within the profession.

"It has come to my attention that the wife of a certain young Congressman is about to have a baby. He went to a doctor to whom a good many Congressmen go and asked him to recommend a physician, which he did. He went to see that doctor, and the doctor said, 'I will be glad to take your case.' When he asked, 'What will you charge me?' the doctor said, '$1,000.'

"I have been told that more than one Congressman has paid $1,000 for these services."

Assuming that the remarks of the gentleman from Pennsylvania are accurate, we're inclined to go along with him in feeling that the charges asked by the physician were exorbitant. Babies just don't come that high any more. But, regrettable as the affair is, the thing that adds insult to injury is to discover that any doc would be dumb enough to pull a trick like that on a Congressman.

CHANGES IN INDUSTRIAL COMMISSION FEE SCHEDULE CONSIDERED

A Sub-Committee on Workmen's Compensation of the Committee on Industrial Health of the Ohio State Medical Association has started a series of meetings and conferences looking toward the preparation of recommendations for revisions of the General and Special Fee Schedules of the Ohio Industrial Commission.

One meeting has been held; others have been scheduled. Representatives of the Commission have been invited to work with the committee. They have done so and will continue to join with the committee in its deliberations.

Many parts of the fee schedules have not been modified since 1926. True, since that time there have been additions to the schedules and some of the individual items have been changed but for the most part the schedules need modernizing, in the opinion of the committee and the medical profession generally. Also, the present printed schedules do not contain some of the important regulations which are used by the Commission in adjudicating fee bills. This has led to misunderstandings between the Commission and physicians.

Therefore, the committee has two chief objectives: (1) To suggest changes in the fees, where necessary, to bring them into line with present-day conditions and (2) to assist the Commission in the preparation of booklets which will set forth important regulations in addition to the fees allowed.

The committee is planning to be deliberate as it tackles this important and involved job. Moreover, it welcomes constructive suggestions from all members of the Ohio State Medical Association.

If you have one or several ideas, submit them in writing to the committee in care of the Headquarters Office of the State Association, Columbus. All suggestions will be analyzed carefully and will be covered in the final report of the committee if they are found feasible.

Obviously, the Commission will have the final say on whatever recommendations may be compiled by the committee but there is reason to feel that the Commission will give sympathetic consideration to those suggestions which are reasonable and workable and will adopt recommendations which it feels will improve methods of administering the Workmen's Compensation Act.

DEATH CERTIFICATE SHOULD BE FILLED OUT ACCURATELY

According to some of the registrars of vital statistics, too many physicians do a sloppy job when it comes to filling out death certificates. These legal documents are of supreme importance for many reasons. Care should be exercised by the physician in furnishing the data required.

The recent issue of the bulletin of the Division of Health, Dayton Department of Public Welfare, gives some "horrible" examples and some timely suggestions on this question. Here are a few—passed on with an appeal that each physician be a little more conscientious in helping the registrar with his official duties:

In the past there has been much confusion regarding the primary and contributory causes of death. A person may have died of pneumonia, for example, which was the result of an attack of influenza. There is a line which says "immediate cause of death". This is followed by two more lines preceded by the words "due to". In the above example there could be hardly any question about the right procedure. The patient died of pneumonia (state type), due to influenza.

"Cardiac Failure." This merely states that

the heart stopped. The cause of the failure must be given.

"Acute Cardiac Dilitation." Was this acute or chronic myocarditis?

"Faulty Elimination." This is not a sensible statement of the cause of death.

"Edema." The word means swelling and refers to a symptom and not to a cause of disease.

"Nephritis." State whether acute or chronic, tubular or glomerular, etc.

"Toxemia." Give type and cause.

"Respiratory Failure." This is equivalent to saying that the person just "ceased to breathe".

"Abdominal Cancer." State the primary focus and the organs involved.

"Hemoptysis, Bronchitis and Chronic Nephritis." This leaves one completely in the dark. Did the patient have tuberculosis or kidney disease?

"Arterio Sclerosis." Together with "Myocarditis" and various other causes in a patient over ninety years of age had better be summed up by the word "senility".

Be sure to state the cause of death in some detail. "Abdominal Tumor" without stating whether it was malignant or benign or "Salpingitis" without showing whether it was gonorrhoeal, puerperal, or traumatic are also examples of incorrect statements. In case of death by trauma state whether it was accidental, homocidal, or suicidal. Always state cause of injury. This is especially true in traffic deaths where there may be compensation from state or other source.

WHERE WAS EVERYBODY WHEN THE ROLL WAS CALLED LAST JUNE?

In our opinion the great majority of the physicians of Ohio will concur in the sentiments expressed in the following excerpt from an editorial published in a recent issue of *The Journal of the Medical Society of New Jersey:*

"Apparently, at least for the time being, there is to be *no office* of the American Medical Association in Washington. We understand, however, that one and perhaps two representatives of the Association will be in Washington to maintain contacts with the various bureaus, and presumably to advise the Council on legislation of interest and import to the profession. While this perhaps is an improvement, we still hold strongly to the conviction that to do a *good* job in public relations, to be in a position to furnish the legislators, the public and the medical profession with needed information concerning legislation or regulations affecting public health and medical service, an adequate staff *with an office in Washington* is essential. If, perchance, an office of the Association is subsequently established in Washington, we suggest a prompt public announcement of the fact and a frank statement of its purposes."

Ohio's delegates fought vigorously for favorable action by the House of Delegates at its meeting last Summer. Wonder where all of those who are now plugging so hard for a Washington office were when the roll was called on the Hein amendment (Ohio amendment) at that meeting?

ADDRESSES ON MALARIA AND DYSENTERIES FEATURED

American civilian physicians have been advised by the Subcommittee on Tropical Diseases of the National Research Council to be familiar with the tropical and subtropical diseases that may be imported to this country by returning members of the military forces.

With the passing months the importance of diagnosis, treatment and control of malaria, the dysenteries, and other diseases now common to the United States at this time will be magnified.

This announcement gives us an opportunity to put in a timely plug for the 1944 Annual Meeting of the Ohio State Medical Association, May 2, 3 and 4, Neil House, Columbus.

Ohio physicians will not have to travel farther than Columbus to get the latest authentic information on malaria and dysenteries as these two subjects will be featured on the Scientific Program.

Now is the time to make hotel reservations for the May meeting and to make plans to attend.

RADICAL PROGRAMS WON'T SOLVE PHYSICIAN SHORTAGES

After reading some of the editorials which have been written in a few newspapers and the publications of labor and welfare journals—apparently by thoroughly uninformed writers—the casual reader would get the impression that the medical profession, and more especially medical organizations, have deliberately set about to produce a shortage of physicians in localities where shortages now exist.

There is a shortage of medical manpower in some areas. There are a few communities in Ohio where the services of additional physicians are needed, although there is no situation which can be termed acute in comparison to conditions in areas in some of the other states. Efforts, especially on the part of the Ohio Procurement and Assignment Committee, to persuade physicians to locate in localities needing doctors have produced some results, although not 100 per cent results.

Those who criticize and want revolutionary tactics followed to remedy this situation have lost sight of a number of important points.

First, the demand of the armed forces for medical officers has been the cause of the conditions which exist in most areas. The military comes first under wartime conditions. To accuse the medical profession of having been responsible, is merely an admission of ignorance.

Second, there is no legal method whereby a physician can be moved from one territory into another.

Third, if there were a legal method to transport physicians from one community into an-

other, it doubtless would result in failure and disappointment. The practice of medicine involves human relationships. What kind of service would a physician render in a community which he would dislike or where the people would lack confidence in him for personal reasons.

Fourth, many of the communities on the list of places needing physicians have always needed physicians—probably always will. The key to this is found in the record of the past 20 or 25 years during which there has been a trend for the states rich in physicians to become richer and for the states poor in physicians to become poorer, largely because of the preference of new graduates to locate in the states which most encourage medical practice. The problem is basically one of economic and social conditions. It won't be solved by subsidizing physicians. Unless environments are improved even the subsidized physician would not last long. Thus, the problem has to be attacked at its source through improvements in living and social conditions.

Those who want to approach the problem backwards, or with ulterior motives, have advocated radical changes in the system of medical practice and all manner of socialistic programs, capitalizing on the war to gain a hearing. Unfortunately a good many people are being misled by this propaganda.

OBLIGATIONS OF THOSE ACCEPTING MATERNITY PROGRAM PATIENTS

Each Ohio physician is at liberty to decide for himself whether or not he wishes to participate in the Emergency Maternity and Infant Care Program for wives and children of enlisted men. Some doctors are caring for patients under the program. Some are caring for such patients independent of the program—many times without submitting a bill for services rendered.

A few cases have been reported where the physician has failed to make clear to the service man's wife that he did not care to take her case under the terms of the program. Naturally, this has led to difficulties at the time a bill for services was presented and after it was too late for the patient to seek the services of a participating physician or to file an application for the benefits provided by the program.

If a physician does not care to participate in the Federal program, he should make this known to the service man's wife at the time of the first visit, thus giving her an opportunity to continue with him on a private physician-patient basis or to seek the services of some physician who is willing to accept her as a patient under the program.

When a physician decides to accept a patient under the program he is obligated to file all papers required at the times specified so the patient will be eligible to the benefits. Also, after accepting the patient under the program he is obligated to stand by that decision and should not at some later date regard the patient as a private patient, expecting her to pay a fee higher than the standardized fees allowed under the program.

"THIS IS THE TIME TO DO SOME STRAIGHT THINKING"

Reflecting on the old year and forecasting on 1944, the *New York State Medical Journal* editorially makes the following pertinent observation which a good many states, Ohio included, should not ignore:

"The question of prepaid medical and hospital insurance remains to a great extent unsolved. It cannot wait forever. Many states of the Union have no prepayment plan at all.

"This record is not good enough. Some experience with the mechanism of prepaid insurance is now available and it can no longer be said that the actual experience is entirely lacking. Granted that this experience is not complete, there is nevertheless available sufficient to warrant a more general experimentation with this type of coverage.

"We believe that this is the time, if ever, to do some straight thinking on this subject. If we are to oppose effectively a national plan for socialized medicine, we must oppose it with an alternative plan on an operating basis, sufficiently widespread to support our contention."

A fitting conclusion to this piece, in our opinion, is the following excerpt from an editorial in the *Medical Annals of the District of Columbia*:

"The point of this editorial is that the defeat of the Wagner-Murray-Dingell Bill, important though it is, will not dispose of important issues involved in providing medical care to the people of this country."

BETTER UNDERSTANDING WITH THE PRESS IS NEEDED

We have harped away for several years at the need for a better relationship between the medical profession and the newspapers. The relationship has to be built up locally, where the newspaper, its editors and managers, and the physicians are all a part of the same community. The county medical society or academy of medicine is the agency which must take the lead in bringing the two groups together.

The following editorial from the *Columbus Academy of Medicine Bulletin* backs us up and points out what can and should be done as a starter by all county units, big and little:

"Fellows, how long can we afford the continued thwackings we take from a hostile press?

"We have traditionally avoided publicity for the almost irrelevant reason that a few narcissists wanted to see their own names and phizzes in print.

"Meanwhile the press evolves our future; and

since news is made, not born, it constructs from the materials at hand, principally governmental releases.

"Now to live 'Without Armour' is a shining ideal, and we would be the last to propose a combative defensive attitude. On the other hand, someone should tell our story. And so—

"We propose that the Academy President be not only permitted but directed to keep liaison with the local press and in proper instance to speak for us. If he needs help in specific fields, the fact of his election should qualify him to authorize other members to supplement his stand."

New Plan of Physical Examinations for Registrants Inaugurated

Beginning February 1, 1944, a preinduction examination plan will be put into effect for all registrants being processed for induction through Selective Service.

As of this date the present local board physical screening examination, including the taking of blood specimen for blood serology, will be discontinued, with the exception of certain registrants who claim to have or appear to have definitely totally disqualifying defects.

Such registrants who appear to have such defects will be referred to the local board examining physician, who will examine the registrant for such defect and determine whether he has a disability which is listed under DSS Form 220 and is totally disqualifying.

The taking of blood specimen in these cases is not required. If defect is found which is totally disqualifying, the local board examining physician will make such entry on DSS Form 221 and the local board may classify the registrant IV-F without forwarding him to the Army Examining-Induction Station.

In a few other instances in which a second blood specimen is required due to loss, breakage, hemolizing, or uncertain report, the registrant will be then referred to the local board examining physician for the taking of this specimen. Also, in cases of incapacitating illness in which the registrant is unable to appear the statement of the attending physician will be referred to the local board examining physician for expression of opinion on the second page of DSS Form 221.

The changes as outlined above will not in any way affect the status or appointment of local examining physicians but simply mean that most of them will not have as many duties to perform as in the past, as the physical examinations with the exceptions referred to, will be made at the induction centers.

The following communication from Col. Howard E. Boucher, chief, Medical Division, Ohio Selective Service Headquarters, on behalf of Col. C. W. Goble, director, was received by the Ohio State Medical Association under date of January 21, and expresses appreciation to the hundreds of Ohio physicians who have been assisting Selective Service during the past three years.

"With the change to preinduction examination, beginning February 1, 1944, we wish to take this means of expressing our deep appreciation to all physicians and others who have assisted them during the past three years in making the local board physical examinations of registrants about to be forwarded for induction.

"These examinations have been of great value to the Selective Service System and the Armed Forces in the great task of processing registrants in preparation for induction for training for military service. All physicians who have accepted the duties and obligations of this appointment, as well as many other physicians who have voluntarily assisted in these examinations, are to be highly commended for their patriotic willingness to render this gratuitous service."

New Selective Service Hernia Rules

Physical standards pertaining to inguinal hernia were changed by the Selective Service System, effective November 11, as follows:

1. Inguinal hernia which **has not** descended into the scrotum is acceptable for limited service.

2. Inguinal hernia which **has** descended into the scrotum is nonacceptable for military service.

Local selective service boards have been instructed to reconsider and re-examine registrants previously rejected at induction station because of inguinal hernia only, and registrants classified IV-F by local boards because of inguinal hernia following local board physical examination.

The boards were also advised that known hernia cases will not be considered as available for filling calls for general military service, but should be sent to induction stations in addition to normal calls for January or succeeding months to determine acceptability for limited service.

To avoid overloading induction stations with such registrants, local boards have been directed to distribute the processing of such hernia cases previously classified IV-F over a period of at least four months.

It is estimated that about 10,000 Ohio registrants will be subject to reclassification under the new hernia rules.

Congress on Industrial Health To Be Held in Chicago, Feb. 15-16

The sixth Annual Congress on Industrial Health, sponsored by the Council on Industrial Health of the American Medical Association, will take place on Feb. 15 and 16, 1944, at the Palmer House in Chicago. These sessions follow directly after those of the Annual Congress on Medical Education and Licensure. Official representatives of medical societies and allied organizations can attend both congresses this year without extra travel.

Continuation of OCD Medical Units As Part of Some Local Government Department Suggested by Regional Officer

THE advisability of keeping the Emergency Medical Service Units which have been formed in hundreds of Ohio communities under the OCD program intact and useful not only for the duration of the war but also after the war as community emergency and protective agencies is emphasized in a communication mailed recently by Dr. William S. Keller, senior surgeon, (R) USPHS and regional medical officer, Office of Civilian Defense, to the chiefs of Emergency Medical Service in the Fifth Service Command, comprising the states of Ohio, West Virginia, Kentucky and Indiana.

Dr. Keller, whose headquarters is at 9 Buttles Avenue, Columbus, points out that valuable literature and equipment have been furnished to the Emergency Medical Service Units and that the personnel has been carefully selected. For that reason, he states, efforts should be made to "coordinate and integrate" the organizations into the needs of city and county departments of government so that they will be available at all times to meet local emergencies and disasters.

TEXT OF COMMUNICATION

Text of Dr. Keller's communication, offering suggestions on this matter which are worthy of consideration by County Medical Societies, chiefs of Emergency Medical Service, OCD, and local government officials, follows:

To the Chiefs of Emergency Medical Service,
Region V

My dear Doctor:

To those of you who have served faithfully for the past two years I am directing this letter of appreciation, thanks, and affection, as well as an appeal for continued cooperation.

It must seem evident to you, as to all observing and thinking people, that our war progress, and the lack of air raids to date, have tended to distract public attention from some very significant values of Civilian Defense. In recognition of this fact, I am asking for your continued cooperation on the following basis:

Those of you who have had letters from me, or who have heard me address your State Medical Association Meeting, or the College of Surgeons Meeting, know that for the past two years I have appealed to you to coordinate and integrate the organization of your Medical Division of OCD into the needs of your City or County Departments of Government. It is not only farsighted and good organization, but it is basically and fundamentally sound, because few of our communities have had well-organized disaster squads for Emergency Medical care (most of them are on paper only) that can serve communities in disasters caused by natural causes and carelessness, as well as by enemy action and sabotage.

In this Fifth Region, we have always emphasized the long-view or long-range plan. At this time, in the interest of our greatest usefulness, it is well for us to re-emphasize this long-view idea.

Our Chief Medical Officer and his Associates in Washington have forecast our needs splendidly, and as a result, many of you have received valuable literature and equipment that have served your Program well. Hence, nothing in this letter to you should alter, take precedence over, or take the place of publications or directives that have been issued from our National Office.

With a changing public attitude, there are two things you should do, not only to anticipate, but also to circumvent disintegration of your effective Medical organization.

1. Continue to advise the civilian population and the personnel of your Emergency Medical Service that the war is not yet won, that there is nothing sure and nothing final until the enemy capitulates. Remind them also of the many wartime disasters throughout the country in which the Emergency Medical Service has been responsible for the saving of many lives. Keep the Emergency Medical Service intact.

2. If you have not already done so, coordinate and integrate your Emergency Medical Service of the OCD into well-established community, city or county departments of government.

All well-ordered and well-organized communities of moderate size have Departments of Public Health, Public Welfare or Public Safety. The Programs of Health, Welfare and Safety predicate and imply Emergency Medical Service, yet our communities have never had this safeguard and this service adequately developed.

It is unlikely that many communities would consider organizing a separate department of government for this service, but most communities would see the value of creating a Division of Emergency Medical Service in one of the already established Departments.

Hence, let us hold on to our Emergency Medical Service, to function as such for the duration. Let us pave the way for our organization to be fully assimilated and integrated after the war into one of these departments, that communities may profit by the training you have received, and the efficiency you have maintained and perfected.

We must be ready to handle disasters from natural and accidental causes in times of peace just as we have been prepared to handle disasters from enemy action and sabotage in time of war. Other agencies may be prepared to give food, shelter and clothing, but to the MEDICAL PROFESSION must be committed MEDICAL CARE, especially in the event of a major catastrophe.

The world is going to be a long time getting straightened out. The MEDICAL PROFESSION must not lose a single opportunity to do its bit now toward making the process shorter and safer.

Continue to consult me regarding any of your problems.

Faithfully yours,

William S. Keller, M.D.
Senior Surgeon (R) USPHS
Regional Medical Officer

WAR NOTES

Selections by Lt. Comdr. T. E. Newell, Dayton, on a piccolo are ridding the Marines on New Britain Island of the blues, according to news dispatches. Dr. Newell has seen plenty of action. He was at Guadalcanal and Cape Gloucester.

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The promotion of Major Donald D. Forward, Ashtabula, from the rank of captain was recently announced from a South Pacific Base. Dr. Forward, who as a captain was head surgeon of the Clearing Company, 112th Medical Battalion, assumes the duties of medical inspector for the 37th Division. He has been with the 37th since its activation on October 20, 1940.

* * *

Glowing reports continue about the Ohio medical officers serving with the 37th Division. The most recent to pay them tribute was 2nd Lt. Joseph Dillehay, who had just received his commission in the Medical Administrative Corps at Camp Barkley, Texas. Previously a sergeant in Collection Headquarters, Lt. Dillehay was selected to attend O.C.S. Interviewed by a newspaper reporter recently, he told of assisting in handling the wounded men of the 37th during the Battle of Munda last July. He recalled assisting Capt. (now Major) Thomas V. Kolb, South Charleston, and Capt. Edward J. Klopfer, Columbus, in surgery. "They operated steadily to keep up with the arrivals," he said. "They did wonderful work. The surgery and hospital tents were so constructed that they could be blanketed to hide the lights. I helped on wounded cases during air raids and several times bomb fragments flew through the canvas walls. But the surgeons didn't appear to realize there was a raid going on, for they kept right on working," he said. According to Lt. Dillehay, out of 400 casualties treated, only one man died.

* * *

Comdr. Harry R. Huston, Dayton, reported at the Great Lakes Naval Training Station January 9, after a leave at home following 20 months' service in the South Pacific, with the Dayton Naval Hospital Unit.

* * *

Capt. W. R. Stager, Dover, who has been on duty as a flight surgeon in the Aleutian area, was home recently on a 15-day leave.

A church service one Sunday in India and the next Sunday in his home town of Canton was the schedule followed by Capt. Robert E. Wirtz who returned to this country in December after 21 months overseas. He has reported at Randolph Field, Texas, for a course in aviation medicine.

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Major Wm. R. Hochwalt, Dayton, is chief of the orthopedic department, 44th General Hospital, in Australia.

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Capt. M. E. Scheetz, Kalida, commanding the Medical Detachment of the 2nd Engr. Bn., APO 2, New York, wants his *Journal* and hopes that the doctors back home are doing everything possible to defeat the Wagner Bill.

* * *

Lt. Col. S. C. Ellis, Xenia, is commanding officer of a 250-bed station hospital in North Africa. He was recently promoted to his present rank.

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Capt. F. J. Denning, Steubenville, writes that he has been receiving *The Ohio State Medical Journal* in India and that it "is always on the welcome list". Dr. Denning is with the 86th Air Serv. Sq., 52nd Air Serv. Gr., APO 466, c/o PM, New York.

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Capt. John A. Riebel, Ashland, is Air Base Surgeon at Fort Dix, N. J. Advising *The Journal* of his change of address, Dr. Riebel writes: "Just came back from Bermuda. We just wanted to see if we could find it in the dark and a storm. 'We dood it.'"

* * *

Lt. Col. Albert M. Johnston, Marysville, is now on duty in the Office of the Surgeon General, Washington, D. C. Dr. Johnston was formerly in the Medical Research Department, Edgewater Arsenal, Md.

* * *

Capt. Albert H. Pearlman, Cincinnati, now taking a course at the Medical Field Service School, Carlisle Barracks, Pa., has a unique war record. His first military service was at the age of 15 when he enlisted in the Navy during World War I. After receiving an honorable discharge, he completed his high school, college and medical education. When volunteers were requested early in 1941 for physicians to serve with the British Army, Dr. Pearlman sailed for England, only to be torpedoed in the North Atlantic. He was rescued by a destroyer after a couple of

hours in the water and returned to this country. Later he started out again, and arrived in Liverpool, where he joined the Royal Army Medical Corps. After service in the British Isles, Dr. Pearlman was sent to the Middle East and saw action with the British Eighth Army in Iran, Iraq, Palestine, Syria and other battle fronts. After receiving his discharge from the R.A.M.C., Dr. Pearlman returned to the United States, and applied for a commission in the Army of the United States. He was commissioned a captain last October. Dr. Pearlman graduated at the University of Cincinnati College of Medicine in 1927.

* * *

Lt. F. Blair Webster, M.C., U.S.N.R., Bellefontaine, now wears the silver wings of a Marine paratrooper. He was assigned to the First Parachute Regiment, First Marine Amphibious Corps shortly after qualifying as a parachutist, and is now "somewhere in the Pacific".

* * *

The correct rank of Dr. Robert G. Lehman, Dayton, whose article "Blood Chemistry and the General Practitioner," appeared in the December issue of *The Journal*, is Lieutenant, Medical Corps, United States Navy. Now in the Regular Navy, Dr. Lehman was previously commissioned in the Naval Reserve.

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Capt. Thomas M. Hayes, Springfield, recently promoted to his present rank, is now stationed at the Suffolk Army Air Base, Long Island, N.Y.

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Another recent promotion was that of Capt. Luther W. High, Millersburg, stationed for the past six months at the Air Base, Greenville, S.C., with the 334th Bomb. Group.

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Capt. Orville L. Layman, Franklin, is in England, attached to the Med. Det., 8th AFRD, APO 635, c/o PM, New York.

* * *

Comdr. Drew L. Davies, Columbus, who was transferred to the West Coast recently after being on duty at the Navy Recruiting Station in Cincinnati, is reported to be "Somewhere in the Pacific". His address: Acorn 26, c/o Fleet Post Office, San Francisco.

* * *

Capt. Wendell Green, Toledo, now at Fitzsimons General Hospital, Denver, says he enjoys *The Journal* a great deal, but wishes the editorial section would be revived. (You'll note that "In Our Opinion" came back to life in the January issue, doctor. We hope to keep it alive.) Dr. Green also writes:

"It has been a source of satisfaction to observe the manner in which the State Association and many of our county societies are opposing the Wagner Bill. If your efforts fail for lack of vigorous prosecution, the fault will lie with the individual members who can not or will not actively support their State Association and component societies."

* * *

Maj. Roy D. Arn, Dayton, chief of the surgical staff of an Army hospital in New Guinea, recently conducted General Douglas MacArthur through the surgery ward of the temporary tent-hospital, according to press dispatches.

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The Air Surgeon has commended Maj. Zolton T. Wirtschafter, Cleveland, for his "diligence and initiative", at Wright Field, Dayton, where he is in charge of civilian medical service.

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Major George G. Hunter, Ironton, recounted some of his Army experiences to members of the local Lions Club, which he addressed while he was home on leave recently. He is stationed "Somewhere in Oregon".

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Lt. Col. T. M. Kirk, Dayton, with the 57th Evac. Hosp., APO 928, c/o PM, San Francisco, V-mails: "*The Ohio State Medical Journal* finally has caught up with me 'Somewhere in New Guinea'. I enjoy the articles, and especially the War Notes. It is a good way of knowing where men are located . . . Mail and magazines, especially *The Journal*, have been most welcome this far away from Ohio."

The Journal will follow you wherever you go, doctor. All we need is your correct address. Then it's up to the APO.

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Two Ohio physicians are prisoners of war in Concentration Camp P.G. 21 in Italy. They are: Capt. Wilbur E. McKee, Bryan, and Capt. Henry J. Wynsen, Youngstown, who were attached to armored units in the Tunisian campaign.

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Capt. L. Courtney Jack, Cincinnati, was recently transferred to the Mason General Hospital, Brentwood, Long Island.

* * *

Running the Physical Therapy and Occupational Therapy departments and the Rehabilitation Program at Billings General Hospital, Ft. Benj. Harrison, Ind., is the assignment of Major Ivan C. Smith, Youngstown, who reports that he is more happily situated than at any time since he has been in the Army.

* * *

Capt. O. A. Axelson, Youngstown, is battalion surgeon in an infantry regiment of an armored division in England. He writes:

"My work has been invigorating and interest-

ing. Twenty-five mile marches and being out and trying to sleep in all kinds of weather seems rather rugged at times but so far I've been able to take it with men most of whom are young enough to be my sons. In our base camp we are comfortably quartered and our meals are generally good although fresh milk, and old fashioned egg in the shell and white bread will be welcomed again. For a while I had the good fortune to be quartered in a fifteenth century castle.

"England with its quaint customs and traditions and places of historical interest, is a good country for sight seeing and I have enjoyed trips to London, Stratford-on-Avon, Oxford and Liverpool. I attended a Thanksgiving service at Westminster Abbey."

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Maj. Charles A. Hulse, formerly on the house staff of University Hospitals, Cleveland, has been awarded the Air Medal in Guatemala for preventing a diphtheria epidemic on a British warship 1,000 miles off the Pacific Coast. According to the citation, Dr. Hulse "undoubtedly saved many lives as well as insured the safety and speedy arrival of the convoy to its destination". The citation further said:

"On Feb. 22, 1943, Maj. Hulse, then a captain, was primarily responsible for preventing a diphtheria epidemic on a British warship 1,000 miles off the Pacific coast.

"After receiving word of the impending epidemic, Maj. Hulse, acting base surgeon, obtained diphtheria serum from a distant hospital. He wrapped it in many layers of cotton, lashed it to a rubber life raft, which was secured by rope in the bomb bay of a Liberator bomber, and then had it flown to the ship.

"The serum then was dropped alongside the warship and picked up by a convoying destroyer in time to check the epidemic."

* * *

Lt. Col. Maurice M. Kane, Greenville, arrived "Somewhere in North Africa" recently with his unit, the 313th Medical Bn., APO 88, c/o PM, New York.

* * *

Major Marvin Sadugor, Cleveland, now stationed in the Southwest Pacific, recently received his majority and was made Base Surgeon of the II Island Air Command. He is with the 578th Signal Air Warning Battalion, APO 913, and has been in the Pacific for almost two years.

* * *

News about Columbus medical officers. . . . Capt. John Quincy Brown who sailed from San Francisco about Dec. 1 is reported to be "Somewhere in New Guinea". This new address is: APO 928, c/o PM, San Francisco. . . . Col. Gerald P. Lawrence is in North Africa. . . . New address of Capt. J. C. Vanneter is Station Hospital, Army Air Base, Salinas, Cal. . . . Capt. Lovell W. Rohr was recently made Executive Officer of the Station Hospital, Army Air Base, Richmond, Va. . . . Chief of the Neuro-Psychiatric Section of the Northington General Hospital at Tuscaloosa, Ala., is the new assignment of Major Nicholas Michael, who had been at Camp Shelby, Miss., for three years. He says he has about 500 N.P. patients, practically all overseas casualties . . . work is interesting and he likes it a lot. . . . Major Kenneth D. Smith has been transferred to the Station Hospital, Rome Army Air Field, Rome, N. Y., where he is chief of Industrial Medicine. . . . Major Harrison Evans is with the 47th General Hospital, APO 9128, c/o PM, San Francisco. . . . Capt. Morris Goldberg is in command of the 845th Medical Hospital Ship Platoon, (SEP), ASFUTC, New Orleans, La. . . . Capt. O. L. Coddington was home for Christmas. His address: Med. Det. 979, F.A. Bn., APO 182A, Unit 14, c/o PM, Los Angeles.

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Lt. Comdr. F. P. Osgood, Toledo, is with the 89th Constr. Bn., Fleet Post Office, San Francisco. Seabees?

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Major Clarence W. Sears, Youngstown, with the 313th Station Hospital, now has the address of APO 9301, c/o PM, New York.

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Little Creek, Va., at the Amphibious Force Training Base, is the new location of Lt. Comdr. H. H. Wyand, Cleveland.

* * *

Capt. Jack Widrich, Cadiz, and Capt. Densmore Thomas, Niles, are attached to the 113th Med. Bn., with the Hdqrs. Co. and Co. B, respectively. Address: APO 38, c/o PM, San Francisco.

* * *

Construction of the 1725-bed Crile General Hospital, Parma Heights, Cleveland, is nearly completed, with the first wounded men scheduled to arrive about Feb. 15, according to a recent statement by Col. Robert D. Harden, the commanding officer. Col. Harden, who has been in the service for 30 years, formerly commanded the Gorgas Hospital in Panama.

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Major Harold F. Wherley, Stone Creek, is on the staff of the Station Hospital, Erie Proving Grounds, La Carne, Ohio.

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"Somewhere in the Aleutians," is the location of Capt. C. O. Porbe, Cleveland, with the 20th Field Hospital, APO 726, c/o PM, Seattle.

* * *

Greetings via V-mail come from Capt. L. H. Brooks, Cleveland, now in England, attached to the Eighth Air Force, "the gang who are giving Herr Shicklegruber such a headache and will

finish the war in a hurry—we hope and pray". Dr. Brooks says he has acquired a taste for warm beer and scotch, but can't get used to the weather.

"The English are very anxious that my stay here be pleasant and you can help complete this picture if you will forward *The Journal* to me at the Station Hospital, 2nd B.A.D., APO 635, c/o PM, New York," he concludes. The February issue will be so-addressed, doctor!

* * *

Ranking officer of Japanese ancestry with a Japanese-American medical unit in Italy, Capt. Isaac Kawasaki, graduate of the University of Cincinnati in 1937, was wounded November 6, and is reported recuperating in a base hospital, probably in North Africa. A native of Hawaii, Dr. Kawasaki received most of his education in the United States. He was practicing in Honolulu when he entered the service in July, 1941. A brother, Dr. Leonard Kawasaki, is also a captain in the Medical Corps of the Army of the United States. He was practicing medicine in Cincinnati prior to being commissoned last October.

* * *

Major H. J. Nimitz, Cincinnati, formerly stationed at Louisville, Ky., is now with the 25th Gen. Hosp., APO 646, c/o PM, New York. Another Cincinnatian, Capt. Eugene H. Sterne, is with the same outfit.

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Comdr. W. H. Perry, Cleveland, is Executive Officer of the Naval Base Hospital, Navy 250, c/o Fleet PO, San Francisco.

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For the past 15 months Capt. L. N. Shroder, Greenville, has been chief of EENT at the Station Hospital, Bowman Field, Louisville, Ky. He was recently promoted to his present rank.

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Capt. O. E. Cress, Van Wert, 231st Station Hosp., APO 551, c/o PM, New York, writes: "We sure do enjoy *The Journal* here in England".

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Lt. Edwin E. Domall, Toledo, is on the USS Arided, c/o Fleet Post Office, San Francisco.

* * *

Previously located at Dow Field, Bangor, Me., Capt. Wm. W. Corwin, Galion, is now at the A.A.F. Redistribution Center, Station No. 1, Atlantic City.

* * *

Capt. Jack Greenfield, Cleveland, V-mails from Italy that he has been receiving *The Journal* regularly despite frequent moves. He is with the 2nd Auxiliary Surgical Group, APO 464, c/o PM, New York.

Capt. John Y. Bevan, Steubenville, with the 317th Station Hospital, now has an APO address. It's APO 9302, c/o PM, New York.

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Major J. J. Del Vecchio, Yorkville, is with the 182nd Station Hospital, APO 782, c/o PM, New York.

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The new address of Capt. Conrad K. Clippinger, Piqua, is 302nd Station Hospital, APO 510, c/o PM, New York.

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Capt. Carl R. Damron, Mansfield, is on the staff of the 105th Evacuation Hospital, APO 184, c/o PM, Los Angeles.

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Written from "Somewhere in the South Pacific" on Christmas Day, Capt. John H. Falk, Cincinnati, advises of his change in address to Hq. Service Command, APO 706, c/o PM, San Francisco.

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Capt. Stephen V. Geroch, Akron, is now with the 88th Bomb. Gp. Disp., APAAF, Avon Park, Fla.

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Major Herman M. Gunn, Ashland, previously at Camp Breckinridge, Ky., with the Med. Sec., 1570 Service Unit, is now addressed APO 9302, c/o PM, New York.

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The Medical and Surgical Relief Committee of America, 420 Lexington Ave., New York City, donated during December, 1943, medical equipment valued at $1,715 to one crashboat squadron and four motor torpedo boat squadrons.

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Directed by Congress to appoint a commission to study and report on the requirements of personnel for admission to the armed services, President Roosevelt selected the following physicians: Rear Admiral Ross T. McIntire, Surgeon General of the Navy; Major General Norman Kirk, Surgeon General of the Army; Dr. Alan C. Woods, ophthalmologist in chief, Johns Hopkins Hospital, Baltimore; Dr. Frank H. Lahey, surgeon in chief, Lahey Clinic, Boston; Dr. Edward A. Strecker, professor of psychiatry, University of Pennsylvania, Philadelphia.

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Lt. John W. Bricker, Cleveland, recently completed the course in aviation physiology at the School of Aviation Medicine, Randolph Field, Texas.

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Capt. Alton W. Behm, Chardon, is with the Medical Detachment, 298th Inf., APO 708, c/o PM, San Francisco.

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Lt. Col. R. J. Borer, Toledo, is at Camp Campbell, Ky., with the 1580th Service Unit.

Additional Notes on Experiences of the Cleveland Clinic Naval Specialist Unit on Duty in the Southwest Pacific

THE following report by Lt. George Crile, M.C., U.S.N.R., Cleveland, on the U. S. Naval Specialist Unit No. 110, appeared originally in the January, 1944, issue of *The Bulletin of the Cleveland Academy of Medicine.* It is a sequel to an article by another member of the Unit, Dr. W. James Gardner, Cleveland, which was published in the April, 1943, issue of *The Bulletin* and reprinted in the June, 1943, issue of *The Journal of the Ohio State Medical Association.* Organized at the Cleveland Clinic, members of the Unit reported for active duty at Brooklyn on March 2, 1942. They landed at Wellington, New Zealand, on May 31, 1942.

* * *

By GEORGE CRILE, Lt., M. C., U. S. N. R., Cleveland, Ohio

ON his return from New Zealand some months ago, Dr. W. J. Gardner published in this journal a few notes on the activities of the Cleveland Clinic Naval Specialist Unit at Auckland, New Zealand. Since Dr. Gardner left Auckland in November, 1942, the members of this unit have been redistributed throughout the South Pacific area and several have either returned home or are on their way home.

Lt. Comdr. R. Kennedy is still in Auckland as chief of surgery of the U. S. Naval Mobile Hospital to which all of us were attached originally. This officer is the only one of the original group who is still in Auckland. The commanding officer, Capt. J. H. Robbins, has been made commanding officer of the Naval Hospital at Treasure Island, San Francisco, and the other officers from the original Cleveland Clinic Unit, Lt. Comdrs. Ernstene, Root, Engel, Nichols, and Lt. Ryan are now stationed in a large base hospital in the islands between New Zealand and Guadalcanal. Lt. Guy Williams has returned to the United States, where he will report to St. Alban's Hospital, St. Albans, Long Island, New York.

SOME ON DESTROYERS

Several other members of the original staff of our mobile hospital, the majority of whom were trained at the Cleveland Clinic, have been assigned duties in the islands nearer the front or aboard destroyers. Lts. L. G. Sinclair and Andrews are on destroyers, and Lt. Zupanec is head of surgery and chief meat inspector of a small tropical island. Lt. Comdr. Blood, neuro-surgeon, is still stationed in Auckland.

The Navy apparently has adopted a policy of rotation of physicians in the South Pacific area, so that there is a constant exchange of physicians between the forward bases in the tropics and the older, more temperate bases in the south. In spite of this system of rotation, the unit was kept together in Auckland for over a year and, since that time, has for the greater part reformed itself in the island base hospital.

As the action moved northward and westward our base at Auckland became progressively further removed from the scene of action. The introduction of air transport, by means of which casualties were flown from the front to the advanced base hospitals, and the development of a number of larger well-equipped base hospitals in the islands north of Auckland resulted in much of the work being done in these new bases instead of on the hospital ships and at the Auckland Hospital. This has unquestionably resulted in more prompt and effective attention for these patients.

Throughout the entire South Pacific area one cannot help being impressed with the quality of the medical and surgical work being done. The hospitals are well equipped, and their personnel is of the highest order of ability. Even in the small advanced bases excellent work is being done, and medical officers are invariably present wherever there is need for them.

MOBILE UNIT BUSY

The Mobile Hospital at Auckland for the fourteen months that I was stationed there was nearly always full to overflowing and handled an enormous number of patients either on their way to evacuation to the Unilted States, or for rehabilitation and return to duty. As time went on, the emphasis was shifted from surgery, which in the beginning constituted the bulk of our work, to the treatment of malaria and other types of tropical disease.

Malaria, with its striking tendency for recurrence, constitutes and will continue to constitute a most serious problem. After the fifth recurrence of the disease most of these patients are considered unfit for further tropical duty and are returned to the United States. Physicians in

The opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

this country, unfamiliar with malaria, will unquestionably be confused by the unexpected symptoms that this disease can produce. Too often malaria is not characterized by the textbook picture of chills and fever, but may masquerade as almost any known disease.

Gastrointestinal symptoms, often simulating appendicitis or an acute abdomen, are commonly seen. Cerebral symptoms, coma, or convulsions, occasionally unaccompanied by any elevation of temperature, may occur. If an upper respiratory infection is coincidentally present, malaria may masquerade as pneumonia. In fact there is almost no symptom which this disease cannot produce, and malaria should always be considered in dealing with a patient from the South Pacific area. Negative blood smears do not rule out malaria, because the parasites may be extremely difficult to demonstrate. However, a therapeutic test with quinine in full doses, given intravenously if necessary, will always result in the prompt subsidence of the symptoms if malaria is the cause of the difficulty.

NEW ZEALANDERS FRIENDLY

During our stay in Auckland we made many friends among New Zealanders, who were extraordinarily hospitable and kind to the Americans. Our hospital was located in the residential district of the town and was built on the site of an old tennis and hockey club. Next door was a bowling club, two miles from the hospital was a splendid golf course, and tennis courts were available not only on the compound but also through the courtesies of friends in the neighborhood. Excellent beaches were situated within a radius of five miles, and within a sixty mile radius were opportunities to hunt duck, swan, pheasant, quail, deer, and wild boar. In addition rainbow trout, weighing as much as 20 pounds, were plentiful in the streams and lakes in the neighborhood of Lake Taupo, about a hundred miles away.

During our stay in New Zealand we had profitable and pleasant relations with the physicians not only of Auckland, but also of Dunedin in the South Island, where the medical school is located. In conjunction with the staff of our American Army general hospital and the local profession, we had a three-day meeting for postgraduate instruction, which was attended by well over a hundred physicians from the North Island. In addition we gave postgraduate courses to two groups of medical students who visited us for two weeks at a time. Four of us had the privilege of traveling to Dunedin to give a series of lectures and clinics to the students of the excellent medical school of Otago. Wherever we went we were received with the most cordial hospitality, and all of us left many friends in New Zealand with whom we hope some day to be able to renew our friendship.

Implication of Waivers of Physical Defects Explained

What are the implications of waivers for known physical defects which physicians sign upon being appointed for limited service in the Army Medical Corps?

The answer to this recurrent question is clarified in a recent opinion on the subject made by the Office of The Judge Advocate General of the Army. The opinion, released by the Procurement and Assignment Service of the War Manpower Commission, is as follows:

"Response is made to your oral inquiry whether acknowledgment, on the accompanying form, of existing physical defects would preclude a person from thereafter claiming benefits to which he would otherwise be entitled on account of the service connected aggravation of such defects. As to the defects acknowledged, the execution of such an instrument merely provides additional evidence of their existence, and to that extent would operate to preclude the person involved from thereafter claiming benefits on account of them. It is the opinion of this office, however, that the mentioned form does not purport to be a waiver of possible future benefits to which the individual might become entitled by reason of any service-connected aggravation of such defects, and would not operate to deprive the individual of any possible benefits on account of such aggravation."

Washington Officials Address Two Academies on Army, Navy Needs

Special meetings of the Cincinnati Academy of Medicine and the Cleveland Academy of Medicine were held on January 18 and January 19, respectively, for the purpose of giving their members an opportunity to hear four officials from Washington speak on current Procurement and Assignment activities, the needs of the armed forces for additional medical officers, how medical personnel is being utilized by the Army, Navy and Public Health Service, and similar war subjects of interest to the medical profession.

Both meetings were well attended and were followed on the succeeding morning by special conferences conducted by the Washington officials and to which physicians classified as available by the Procurement and Assignment Service were invited.

The Washington officials who spoke at the meetings and conducted the interviews were: Dr. Paul C. Barton, assistant executive director, Procurement and Assignment Service, War Manpower Commission; Lt. Col. D. G. Hall, representing the Surgeon General of the Army; Commander F. J. Braceland, representing the Surgeon General of the Navy, and Dr. J. A. Trautman, representing the Surgeon General of the U. S. Public Health Service.

Committee to Formulate Mental Health Program for Ohio Named by Governor; Studies Already Initiated

THE committee appointed by Governor Bricker to study mental health and welfare problems met at the office of the Governor Monday, January 3, with the Advisory Council to the Division of Mental Diseases. The Governor requested the members of the committee and the Council to assist him and the Department of Public Welfare in formulating a long-term mental health program for Ohio. The Governor suggested, and it was unanimously agreed by the members of the committee and Council that they would act as a single committee.

The Governor requested the committee to make a thorough study of all phases of mental health, including the institutions of the State dealing with that subject.

The committee organized by the selection of Hal H. Griswold, Cleveland, former director of the State Department of Public Welfare, as chairman; and Dean Leonard W. Mayo of the School of Applied Social Sciences of Western Reserve University, as vice-chairman. Provision was made for the employment of a secretary.

The committee, recognizing that many studies have been made in this field in Ohio, and that a large amount of valuable material has been accumulated, decided to take full advantage of what has already been done, and to formulate a program that will accomplish many of the objectives which have been repeatedly emphasized in studies of this kind.

THREE MAIN DIVISIONS

The committee recognized three main divisions of the Governor's assignment:

(1) The mentally ill, including epileptics;
(2) The feeble-minded or mentally deficient;
(3) The defective delinquents and psychopaths.

The chairman was authorized to appoint a sub-committee on each of these three divisions, as well as a sub-committee to coordinate their work. Each of these study committees will make recommendations in its field concerning prevention, treatment, education, research, institutional and other personnel, buildings and equipment, and pertinent statutes.

The committee expects to make a report to the Governor at a date sufficiently in advance of the next session of the General Assembly to permit full public discussion of the recommendations.

PERSONNEL OF COMMITTEE

The committee, consisting of the committee appointed by the Governor and the members of the Advisory Council to the Division of Mental Diseases, will be known as "The Governor's Committee on the Mental Health Program for Ohio". The membership is as follows:

Dr. J. F. Bateman, Supt., Columbus State Hospital, Columbus; Dr. R. E. Bushong, Supt., Lima State Hospital, Lima; Judge Charles E. Chittenden, Lucas County Probate Judge, Toledo; Judge Oscar Gast, Marion County Probate Judge, Marion; Dr. W. W. Greulich, Department of Anatomy, Western Reserve University, Cleveland.

Hal H. Griswold, Attorney, Cleveland; Dr. George T. Harding, Psychiatrist, Columbus; Dr. Arthur T. Hopwood, Supt. Inst. for Feeble-Minded, Apple Creek; Dr. Louis J. Karnosh, Psychiatrist, Cleveland City Hospital, Cleveland; Bleecker Marquette, Executive Secretary, Public Health Federation, Cincinnati.

Dean Leonard W. Mayo, School of Applied Social Sciences, Western Reserve University, Cleveland; Fred W. Schwenck, member, Longview Social Service League, Cincinnati; Judge Clifford M. Woodside, Mahoning County Probate Judge, Youngstown.

Mr. Herbert R. Mooney, director of the Department of Public Welfare, and Mr. Charles L. Sherwood, chairman of the Pardon and Parole Commission, were requested by the committee to serve in consultant capacities.

Chicago Medical Society Lectures

The Council of the Chicago Medical Society is sponsoring an Annual Clinical Conference at the Stevens Hotel, Chicago, March 14, 15, 16 and 17. Plans have been made for four intensive post-graduate days consisting of half-hour lecture and clinical periods beginning at 8:00 A. M. and continuing until 5:30 P. M. each day, with intermissions for luncheons and inspection of technical and scientific exhibits. Several one hour "panels" have been arranged. Popular subjects will be covered by specialists in their respective fields.

A dinner will be held on Wednesday evening with a speaker of national reputation on some non-medical subject. All scientific sessions will be held in the Grand Ball Room of the Stevens Hotel. Registration fee will be $5.00. It is advisable to make room reservations early.

Sub-Par Medical School To Close

The Kansas City University of Physicians and Surgeons, long a sore spot in medical education, has agreed to surrender its charter and quit business, June 1, 1944, Dr. James Stewart, state health commissioner, Jefferson City, Mo., has announced.

In Memoriam

Louis Peter Alff, M.D., Piqua; Friederich-Wilhelms University, Berlin, Germany, 1878; aged 92; died December 24. Dr. Alff practiced in Piqua for over 60 years, having settled there shortly after his arrival in this country. His sole survivors are two sisters in Germany.

John Neal Carnes, M.D., Gallipolis; Ohio State University College of Medicine, 1940; aged 30; died December 10. A flight surgeon, Capt. Carnes was killed in an airplane crash in Hawaii in line of duty. Surviving are his widow, his father and a son.

Frederick S. Clapp, M.D., Middlefield; Western Reserve University School of Medicine, Cleveland, 1884; aged 81; former member of the Ohio State Medical Association and the American Medical Association; died January 2. Descendant of a pioneer family which settled in Geauga County 140 years ago, Dr. Clapp practiced there for over 50 years. He was a Mason. Two daughters and a son survive.

Olen Edgar Chenoweth, M.D., Lima; Starling Medical College, Columbus, 1903; aged 65; former member of the Ohio State Medical Association and the American Medical Association; died December 20. He had practiced in Lima for many years.

James Homer Cook, M.D., New Carlisle; Pulte Medical College, Cincinnati, 1883; aged 88; died December 31. Dr. Cook practiced in Clark County for nearly 60 years. He had served as a trustee of the Masonic Lodge at New Carlisle for more than 30 years and was an elder in the Presbyterian Church. Dr. Cook was recognized as a leader in community affairs.

Townsend H. Dickinson, M.D., Dayton; Miami Medical College, Cincinnati, 1906; aged 61; member of the Ohio State Medical Association and Fellow of the American Medical Association; died December 3. A former chief of staff of Miami Valley Hospital, Dr. Dickinson practiced in Dayton for 23 years. He was previously located in Germantown for 10 years. Dr. Dickinson was a member of the Methodist Church and the Kiwanis Club. Surviving are his widow, two sons and two sisters.

Earl M. Gilliam, M.D., Columbus; Starling Medical College, Columbus, 1888; aged 77; former member of the Ohio State Medical Association and the American Medical Association; died December 21. Dr. Gilliam retired last March after practicing in Columbus for 55 years. He had served on the staff of St. Anthony's Hospital since it was opened in 1891. Dr. Gilliam was an emeritus-member of the Columbus Academy of Medicine and a member of the Masonic Lodge. Surviving are his widow; a son, Dr. David B. Gilliam, Columbus, and a sister.

Albert Thomas Grills, M.D., Lorain; Western Reserve University School of Medicine, 1904; aged 66; former member of the Ohio State Medical Association and the American Medical Association; died December 19. Dr. Grills practiced in Lorain for 38 years. He was a member of the Church of the Redeemer. His son, two brothers and two sisters survive.

Thomas F. Higgins, M.D., Toledo; Milwaukee Medical College, 1912; aged 56; member of the Ohio State Medical Association and the American Medical Association; died December 17. Dr. Higgins opened an office in Toledo in 1912, and in 1933 was appointed superintendent of the Lucas County Home and Hospital. He resigned that post last March to return to general practice. During World War I he was a lieutenant in the Medical Corps of the United States Army. Dr. Higgins was a member of the American Legion, Catholic Church and the Knights of Columbus. His widow and a son survive.

James Wm. McLaughlin, M.D., Rossville, Ill., Ensworth Medical College, St. Joseph, Mo., 1893; aged 77; died December 16. Dr. McLaughlin practiced in Dayton from 1908 until failing health forced his retirement in 1941. A son and a sister survive.

John W. Millette, M.D., Dayton; Ohio Medical University, Columbus, 1903; aged 80; member of the Ohio State Medical Association, Fellow of the American Medical Association and the American Board of Otolaryngology; died December 28. Dr. Millette was a school teacher at Dunkirk and New Carlisle for 11 years before he began the study of medicine. He practiced in Dayton for 40 years, and was prominent in his specialty. Dr. Millette was active in Dayton Masonic circles; charter member and former president of the YMCA Discussion Club, and a member of the Methodist Church. His widow, a sister and a daughter survive.

Charles L. Moore, M.D., Cleveland; Cleveland-Pulte Medical College, 1899; aged 71; member of the Ohio State Medical Association and Fellow of the American Medical Association; died January 6. A practicing physician in Cleveland for 45 years, Dr. Moore was president of the Physicians Hospital Association which operates Grace Hospital. He was also a member of the Huron Road hospital staff and the Milk Commission of Cleveland. For many years Dr. Moore



A W O L

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had been an elder of the Presbyterian Church and a member of the Masonic Lodge. Surviving are his widow and five brothers.

Emory Albert Powell, M.D., Cleveland; Starling Medical College, Columbus, 1895; aged 81; former member of the Ohio State Medical Association and the American Medical Association; died December 21. Dr. Powell practiced in Cleveland for nearly 50 years. He taught chemistry at Ohio Northern, Ada, for several years before beginning the study of medicine. A classmate of the late U. S. Senator Frank B. Willis at Ohio Northern, Dr. Powell was active in Cleveland Republican circles. His son, a brother and a sister survive.

Hugh Daniel Schell, M.D., Hamilton; Hahnemann Medical College and Hospital of Philadelphia, 1906; member of the Ohio State Medical Association and the American Medical Association; died December 14. Dr. Schell practiced in Hamilton for 37 years. He was a member of the Masonic Lodge, B.P.O.E., United Presbyterian Church and Phi Delta Theta. Five sisters and a brother survive.

Thomas Henry Shorb, M.D., Canton, Ohio Medical University, Columbus, 1903; aged 69; former member of the Ohio State Medical Association and the American Medical Association; died December 16. A former coroner and councilman, Dr. Shorb practiced in Canton for 40 years. He was a captain in the Army Medical Corps during World War I. Dr. Shorb was a member of the Methodist Church, Masonic Lodge, I.O.O.F., and the Canton Medical Library Association. Surviving are his widow, two sons and two brothers, one of whom is Dr. J. E. Shorb, Canton.

Morris Dan Stepp, M.D., Cleveland; Western Reserve University School of Medicine, 1893; aged 72; member of the Ohio State Medical Association and Fellow of the American Medical Association and the American College of Surgeons; diplomate of the American Board of Surgery; died January 14. A former professor of operative surgery at the College of Physicians and former professor of clinical surgery at Western Reserve University, Dr. Stepp practice in Cleveland for 50 years. Since 1911 he had been consulting surgeon for the New York Central Railroad and chief surgeon in Cleveland for the Pennsylvania Railroad. His widow and a son survive.

Walter King Stewart, M.D., Sandusky; Jefferson Medical College of Philadelphia, 1924; aged 45; member of the Ohio State Medical Association and Fellow of the American Medical Association; died December 17. Dr. Stewart was medical director of the Plum Brook Ordnance Plant. He had previously practiced in Youngstown for 17 years. Widely known throughout the state, Dr. Stewart had been active in organized medicine. He was a past-president of the Mahoning County Medical Society, which he represented in the House of Delegates of the Ohio State Association several times. Dr. Stewart was chairman of the State Association's Committee on Poor Relief. He was a member of the Methodist Church. Mrs. Stewart preceded him in death by only a month. A daughter, a son, his parents and a brother survive.

Finley Van Orsdall, M.D., Baton Rouge, La.; Medical College of Ohio, Cincinnati, 1902; aged 70; former member of the Ohio State Medical Association and the American Medical Association; died January 11. Dr. Van Orsdall was well known throughout Ohio, having been chief of the Division of Communicable Diseases of the State Department of Health for 15 years. He retired three years ago. Surviving are his widow and two daughters.

Columbus—A study of local hospital facilities in relation to needs will be conducted by Dr. Fred C. Carter, superintendent of St. Luke's Hospital, Cleveland. He was chosen by an advisory committee appointed by Dr. Russel G. Means, president of the Metropolitan Health Council.

CHICAGO MEDICAL SOCIETY ANNUAL CLINICAL CONFERENCE

Stevens Hotel

March 14, 15, 16, 17

Because of the added work imposed on physicians by the War, an intensive postgraduate conference is being arranged. Various subjects will be presented in the most practical way so as to be of immediate assistance to physicians in their daily practice. Men in the service, as well as distinguished leaders in civilian practice, will take part in the program.

Wednesday evening will be given over to a banquet addressed by a non-medical man on a subject of interest to the ladies as well as to the physicians.

Final programs will be mailed to every physician in the state.

Registration fee, $5.00.

Hotel reservations should be made early.

Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

HAMILTON

The following programs were presented by the Academy of Medicine of Cincinnati during January:

Jan. 4—"Treatment of Compound Fractures", Dr. J. Albert Key, professor of clinical orthopedic surgery, Washington University School of Medicine, St. Louis, Mo.

Jan. 18—"Surgical Manifestations of Congenital Malformations of the Alimentary Tract", Dr. William E. Ladd, professor of child surgery, Harvard Medical School, Boston, Mass. (The Benjamin Rachford Lecture.)—Bulletin.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CHAMPAIGN

The following Urbana physicians have been elected officers of the Champaign County Medical Society for 1944: Dr. E. D. Buhrer, president; Dr. E. R. Earle, president-elect; Dr. L. Ansel Woodburn, secretary-treasurer; Dr. Mark C. Houston, chairman, Legislative Committee; Dr. N. M. Rhodes, chairman, Committee on War Participation.—L. Ansel Woodburn, M.D., secretary.

GREENE

Dr. Gertrude Howe, resident physician at Children's Hospital, Cincinnati, spoke on "Influenzal Meningitis", at a meeting of the Greene County Medical Society, in the society's room in the Court House, Xenia, December 2.—News clipping.

DARKE

Officers of the Darke County Medical Society for 1944 are: Dr. J. E. Gillette, Versailles, president; Dr. J. W. Van Lue, Gettysburg, vice-president; Dr. W. D. Bishop, Greenville, secretary-treasurer; Dr. A. F. Sarver, Greenville, chairman, Legislative Committee; Dr. C. J. Mills, Greenville, chairman, Committee on War Participation; Dr. C. I. Stephen, Ansonia, delegate; Dr. P. G. Lenhert, Arcanum, alternate.—W. D. Bishop, M.D., secretary.

MIAMI

"Industrial Medicine" was the topic discussed at a luncheon meeting of the Miami County Medical Society, January 6, when members were the guests of Dr. Maynard C. Kiser and the International Flare-Signal Division of the Kilgore Manufacturing Company, Tipp City. A tour of the plant followed luncheon at the plant cafeteria.—G. A. Woodhouse, M.D., secretary.



MONTGOMERY

Dr. R. K. Bartholomew spoke on "Treatment of Diabetic Acidosis" and Dr. H. F. Koppe discussed "Obesity", at a meeting of the Montgomery County Medical Society, January 7, at Dayton. The meeting opened with a complimentary buffet supper at 6:30, with the program beginning at 7 P.M., and ending at 8 P.M., so as not to interfere with evening office hours or other plans for the evening.—Bulletin.

Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

AUGLAIZE

At a meeting of the Auglaize County Medical Society, December 9, at Wapakoneta, the following officers were elected for the ensuing year: Dr. T. H. Will, Minster, president; Dr. A. W. Veit, Wapakoneta, vice-president; Dr. E. A. Gomolski, Minster, secretary-treasurer.

Dr. Guy E. Noble, St. Marys, Third District Councilor, spoke on "The Wagner-Murray-Dingell" bill.—E. A. Gomolski, M.D., secretary.

HARDIN

Officers of the Hardin County Medical Society for 1944 are: Dr. H. E. Gibson, Kenton, president; Dr. F. M. Elliott, Ada, vice-president; Dr. R. H. Zeis, Kenton, secretary-treasurer; Dr. Elliott, chairman of the Legislative Committee and the Committee on War Participation; Dr. R. G. Schutte, Kenton, chairman, Committee on Industrial Health; Dr. C. L. Johnson, Kenton, chairman, Committee on Recreation and Physical Fitness.—Robert H. Zeis, M.D., secretary.

MARION

Dr. Richard L. Morgan spoke on "Tropical Diseases" at an evening meeting of the Marion County Academy of Medicine, January 4, in the new wing of the City Hospital. A lunch prepared by the Woman's Auxiliary, was served following the meeting.—News clipping.

ALLEN

The following Lima physicians are officers of the Lima and Allen County Academy of Medicine for 1944: Dr. H. L. Stelzer, president; Dr. Donald W. English, vice-president; Dr. Chester Badertscher, secretary; Dr. J. R. Tillotson, treasurer.

Motion pictures of "Cancer of the Breast and Radical Mastectomy" were shown at a meeting of the Academy, January 18, at the Lima Memorial Hospital.—Chester Badertscher, M.D., secretary.

MERCER

Officers of the Mercer County Medical Society for 1944 are: Dr. John J. Shea, Coldwater, president; Dr. R. G. Schmidt, Celina, vice-president; Dr. A. J. Rawers, Celina, secretary-treasurer; Dr. P. W. Fishbaugh, Mendon, chairman, Legislative Committee; Dr. W. C. Scheidt, Celina,

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censor; Dr. C. P. Adkins, Coldwater, delegate; Dr. M. L. Downing, Rockford, alternate.—A. J. Rawers, M.D., secretary.

VAN WERT

The following Van Wert physicians are officers of the Van Wert County Medical Society for 1944: Dr. W. E. Lawhead, president; Dr. R. E. Shell, vice-president; Dr. G. A. Edwards, secretary-treasurer; Dr. C. R. Keyser, chairman, Legislative Committee; Dr. Shell, chairman, Committee on War Participation; Dr. J. R. Sampsell, Van Wert, chairman, Committee on Recreation and Physical Fitness.—G. A. Edwards, M.D., secretary.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

DEFIANCE

"Industrial Medicine", was the topic discussed at a meeting of the Defiance County Medical Society, January 14, at Defiance. Speakers were: Dr. Barney J. Hein, Toledo, chairman, Committee on Industrial Health, Ohio State Medical Association; Dr. A. A. Brindley, Toledo, Fourth District Councilor; and Dr. Robert H. Elrod, Toledo, chairman of the Committee on Industrial Health, Toledo Academy of Medicine.

FULTON

Officers of the Fulton County Medical Society for 1944 are: Dr. A. M. Wilkins, Delta, president; Dr. P. S. Bishop, Delta, vice-president; Dr. L. C. Cosgrove, Sr., Swanton, secretary-treasurer; Dr. L. E. Botts, Wauseon, chairman, Legislative Committee; Dr. E. R. Murbach, Archbold, chairman, Committee on Public Relations; Dr. C. L. Hutchins, Delta, chairman, Committee on Medical Economics.—L. C. Cosgrove, Sr., M.D., secretary.

HENRY

The Henry County Medical Society has re-elected the following officers for 1944: Dr. J. J. Harrison, Napoleon, president; Dr. Thomas Quinn, Napoleon, vice-president; Dr. J. R. Bolles, Napoleon, secretary-treasurer; Dr. Bolles, chairman, Legislative Committee; Dr. B. L. Johnson, Deshler, chairman, Committee on War Participation.—J. R. Bolles, M.D., secretary.

LUCAS

The Toledo Academy of Medicine presented the following programs during January:

Jan. 7—Forty-Second Annual Meeting. Guest speaker, Grove Patterson, editor of the *Toledo Blade*, who gave an inspiring account of his recent trip to England. Dr. Fred M. Douglass, retiring Chairman of the Board of Trustees, was presented with a Certificate af Appreciation by the Council of the Academy in recognition of his unselfish service and earnest devotion to the aims and principles of organized medicine. Dr. Paul M. Holmes assumed the duties of president of the academy. Election results were announced as follows: Dr. J. L. Stifel, president-elect; Dr. A. A. Brindley, member of the Board of Trustees; Dr. M. E. Goodrich, member of Council, and Dr. Rollin Kuebbeler, secretary. There were 149 present at the banquet and 172 at the meeting—the largest attendance since 1939.—George W. Cooley, executive secretary.

Jan. 14—Section of Pathology, Experimental Medicine and Bacteriology. Program by Robinwood Hospital Staff: "Diseases of the Thyroid Gland", Drs. Norris Gillette, E. R. Marker, A. H. Schade, and M. A. Strawbridge, discussants.

Jan. 21—Medical Section. Pathological-Clinical Conference: "Post-Puerperal Sepsis, Nephritis, and Severe Anemia—With Use of Penicillin". Discussants: Drs. B. H. Carroll, Foster Myers, W. B. Sloan, and J. B. Rucker.

Jan. 27—Joint Dinner Meeting with the Woman's Auxiliary. Dr. Jonathan Forman, Colum-

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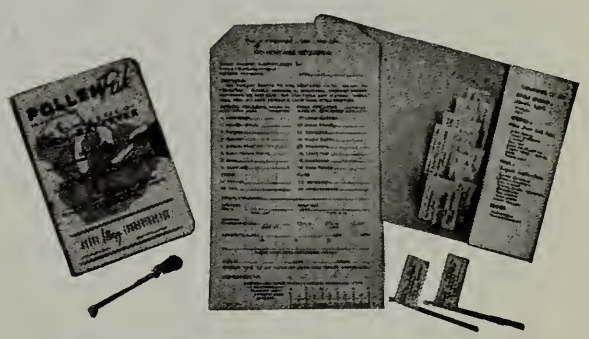
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bus, editor of *The Ohio State Medical Journal*, guest speaker.

Jan. 28—Surgical Section. "The Subject of Lobotomy", Dr. H. E. LeFever, Columbus.—Bulletin.

PAULDING

Officers of the Paulding County Medical Society for 1944 are: Dr. A. F. Burson, Oakwood, president; Dr. R. H. Mouser, Paulding, vice-president; Dr. D. E. Farling, Payne, secretary-treasurer; Dr. K. C. Evans, chairman, Legislative Committee.—D. E. Farling, M.D., secretary.

WOOD

The following physicians are officers of the Wood County Medical Society for 1944: Dr. Frank V. Boyle, Bowling Green, president; Dr. E. H. Mercer, Sr., secretary-treasurer; Dr. D. R. Barr, Grand Rapids, chairman, Legislative Committee; Dr. F. D. Halleck, Bowling Green, chairman, Committee on War Participation; Dr. F. L. Sterling, Bowling Green, chairman, Committee on Industrial Health.—F. V. Boyle, M.D., secretary.

Fifth District

(COUNCILOR: E. P. McNAMEE, M.D., CLEVELAND)

CUYAHOGA

The Academy of Medicine of Cleveland presented the following programs during January:

Jan. 7—Clinical and Pathological Section. "Neurological Complications in Polycythemia Vera", Dr. Louis J. Karnosh; "Recovery in Poliomyelitis Patients Receiving Early Treatment", Dr. J. A. Toomey; "So-called 'Arc-Welders' Disease", Dr. R. C. McKay; "Lobectomy for Bronchiectasis: Demonstration of Cases", Dr. S. O. Freedlander; "Problems in the Clinical Diagnosis of Angina Pectoris", Dr. R. W. Scott; "Pathological Specimens", Dr. H. Z. Lund.

Jan. 19—Joint Meeting, Experimental Medicine Section, Clinical Society of University Hospitals of Cleveland and the Cleveland Section of the Society for Experimental Biology and Medicine. "The Development of Autonomy in Spontaneous Tumors", Dr. Harry S. N. Greene, professor of pathology, Yale University School of Medicine.—Bulletin.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

MAHONING

Dr. W. W. G. Maclachlin, associate professor of medicine, University of Pittsburgh School of Medicine, spoke on "Pneumonia", at a meeting of the Mahoning County Medical Society, January 18, at the Youngstown Club, Youngstown.—Bulletin.

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cers of the society for 1944: Dr. Elmer H. Nagel, president; Dr. Wm. H. Bunn, president-elect; Dr. G. M. McKelvey, secretary; Dr. Saul Tamarkin, treasurer; Dr. M. J. Kocialek, chairman, Legislative Committee; Dr. J. C. Hall, chairman, Committee on War Participation; Dr. P. H. Kennedy, chairman, Committee on Industrial Health.—Mary B. Herald, executive secretary.

SUMMIT

Officers of the Summit County Medical Society for 1944 are the following Akron physicians: Dr. Robert F. Thaw, president; Dr. Joseph M. Ulrich, president-elect; Dr. Richard A. Gregg, secretary; Dr. Charles E. Held, treasurer; Dr. Roger E. Pinkerton, chairman, Legislative Committee; Dr. Walter A. Hoyt, Sr., chairman, Committee on War Participation; Dr. Donald B. Lowe, chairman, Committee on Industrial Health; Dr. Carl R. Steinke, chairman, Committee on Recreation and Physical Fitness.—Jean Hagstrom, office secretary.

Dr. Lawrence N. Atlas, Cleveland, clinical instructor, Department of Surgery, Western Reserve University School of Medicine, spoke on "Diagnosis of Arterial Disease of the Extremities", at a meeting of the society, January 4, at the Mayflower Hotel, Akron.—Bulletin.

Seventh District

(COUNCILOR: CARL A. LINCKE, M. D., CARROLLTON)

BELMONT

The Belmont County Medical Society has elected the following officers for 1944: Dr. C. W. Lose, Flushing, president; Dr. J. B. Martin, St. Clairsville, president-elect; Dr. C. W. Kirkland, Bellaire, secretary-treasurer; Dr. R. H. Wilson, Martins Ferry, chairman, Legislative Committee; Dr. F. P. Sutherland, Martins Ferry, chairman, Committee on War Participation; Dr. H. E. Ring, chairman, Committee on Industrial Health; Dr. Lose, delegate; Dr. J. B. Martin, St. Clairsville, alternate.—C. W. Kirkland, M.D., secretary.

CARROLL

Officers of the Carroll County Medical Society for 1944 are: Dr. Joseph D. Stires, Malvern, president; Dr. Glenn C. Dowell, Carrollton, vice-president; Dr. P. S. Whiteleather, Minerva, secretary-treasurer; Dr. Carl A. Lincke, Carrollton, chairman, Legislative Committee; Dr. J. H. Murray, Carrollton, chairman, Committee on War Participation; Dr. S. L. Weir, Minerva, chairman, Committee on Industrial Health; Dr. W. G. Lyle, Minerva, chairman, Committee on Recreation and Physical Fitness.—P. S. Whiteleather, M.D., secretary.

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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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TUSCARAWAS

A meeting of the Tuscarawas County Medical Society was held in the Council Chamber of the City Hall, New Philadelphia, January 13, with 25 members present. The program, in charge of Dr. Burrell Russell, was a discussion of the common cold and influenza. Mrs. Edna Streb gave a very interesting talk on the Kenny Treatment of Infantile Paralysis. She recently returned from Philadelphia after a special course of study in that treatment.—D. M. Ceramella, M.D., secretary.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

FAIRFIELD

The following physicians are officers of the Fairfield County Medical Society for 1944: Dr. H. C. Kurtz, Millersport, president; Dr. C. B. Crow, Lancaster, vice-president; Dr. C. W. Brown, Lancaster, secretary-treasurer; Dr. C. G. Axline, Lancaster, chairman, Legislative Committee; Dr. C. H. Hamilton, Lancaster, chairman, Committee on War Participation; Dr. C. B. Snider, Lancaster, chairman, Committee on Industrial Health.—C. W. Brown, M.D., secretary.

GUERNSEY

The Guernsey County Medical Society entertained the members of the medical staff of the Fletcher General Hospital and their wives at a turkey dinner, December 16, at the Cambridge Country Club. The guest speaker was Dr. Felix Held, professor of economics, Ohio State University, Columbus. There were 78 persons present. —M. S. Lawrence, M.D., secretary.

WASHINGTON

Officers of the Washington County Medical Society for 1944 are: Dr. J. A. McCowan, Marietta, president; Dr. W. E. Radcliffe, Caldwell, vice-president; and Dr. M. S. Muskat, Marietta, secretary-treasurer.—Edgar W. Hill, Jr., retiring secretary.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

JACKSON

Dr. J. L. Frazer, Wellston, is president and Dr. W. B. Taylor, secretary-treasurer of the Jackson County Medical Society for 1944.—C. C. Fitzpatrick, M.D., retiring secretary.

SCIOTO

Mrs. Dana F. Robinson, field secretary, Planned Parenthood Federation of Ohio, gave an informative talk on the purposes of that organization at a meeting of the Hempstead Academy of Medicine, January 10, in the Nurses' Home, Portsmouth General Hospital.—Thomas W. Frame, M.D., secretary.

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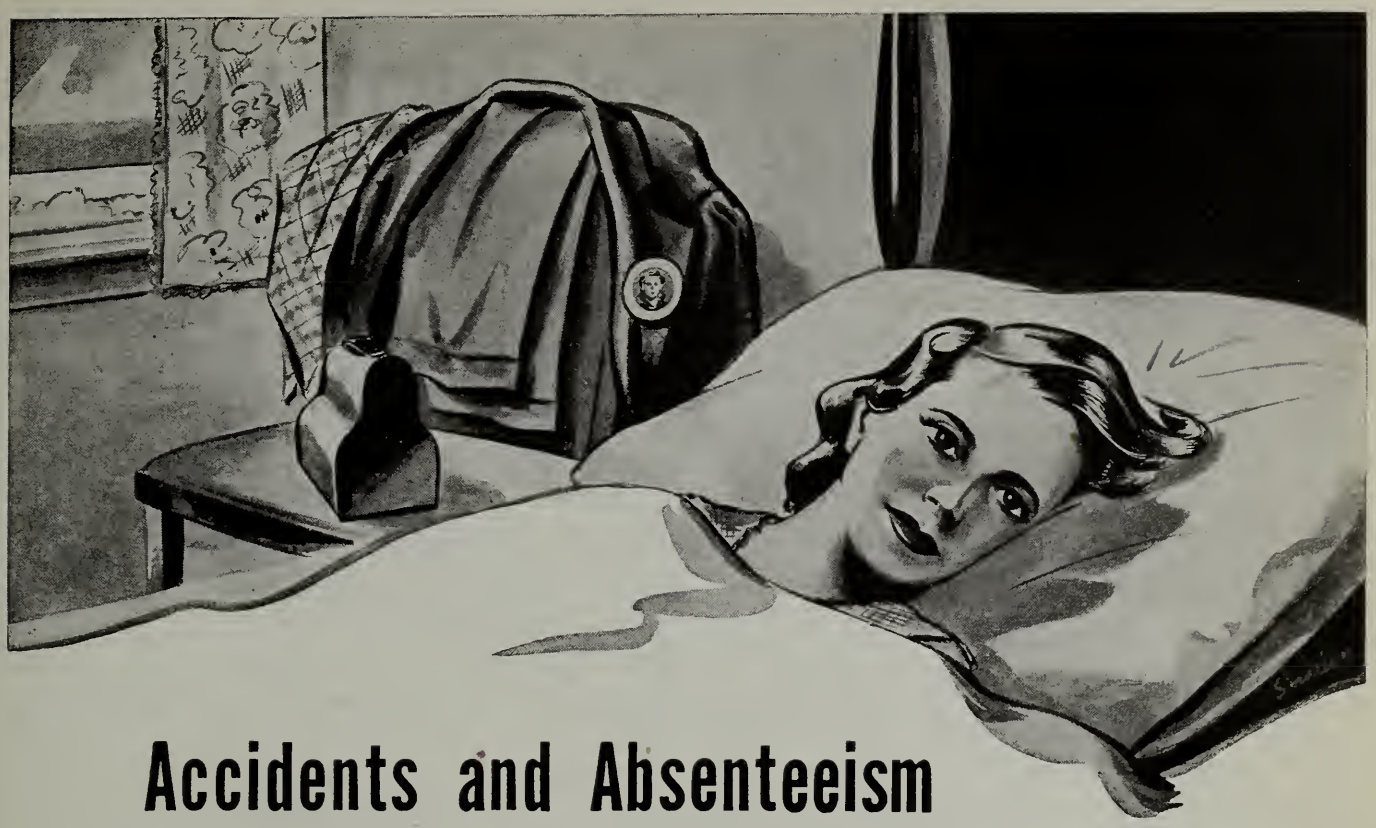
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Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

DELAWARE

The following physicians are officers of the Delaware County Medical Society for 1944: Dr. Elizabeth Workman Lash, Delaware, president; Dr. F. M. Stratton, Delaware, secretary-treasurer; Dr. D. S. Cowles, Ostrander, chairman, Legislative Committee; Dr. F. V. Miller, chairman, Committee on War Participation; Dr. M. S. Cherington, Delaware, chairman, Committee on Industrial Health; Dr. Lash, chairman, Committee on Recreation and Physical Fitness.—F. M. Stratton, M.D., secretary.

FRANKLIN

The Columbus Academy of Medicine presented the following programs during January:

Jan. 10—"Physiology of High Altitude Flying", Fred A. Hitchcock, Ph.D., associate professor of physiology, Ohio State University.

Jan. 31—"Everyday Cancer Problems", Dr. Louis C. Kress, Albany, N. Y., director, Division of Cancer Control, Department of Health of the State of New York. Discussion led by: Drs. Andre Crotti, Wm. Morrison, E. J. Stedem and Ben R. Kirkendall.—Bulletin.

ROSS

At a meeting of the Ross County Academy of Medicine, January 6, at Chillicothe, a resolution was unanimously adopted expressing deep appreciation to Dr. O. L. Iden who, for two years as president of the academy, never missed a meeting.

Guest speakers were: Dr. Norris E. Lenahan, assistant professor of surgery, Ohio State College of Medicine, who spoke on "Anesthesia", and Mrs. Dana F. Robinson, who discussed the work of the Maternal Health Association of Ohio.—News clipping.

UNION

Officers of the Union County Medical Society for 1944 are: Dr. Angus McIvor, Marysville, president; Dr. B. E. Ingmire, Plain City, vice-president; Dr. James M. Snider, Marysville, secretary-treasurer; Dr. F. C. Callaway, Marysville, chairman, Legislative Committee and Committee on Industrial Health; Dr. F. M. Wurtsbaugh, Richwood, chairman, Committee on War Participation and Committee on Recreation and Physical Fitness.—James M. Snider, M.D., secretary.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

ASHLAND

The following Ashland physicians are officers of the Ashland County Medical Society for 1944: Dr. L. Harold Martin, president; Dr. E. L. Clem, Ashland, president-elect; Dr. R. P. Joyce, secretary-treasurer; Dr. M. D. Shilling, chairman,

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LORAIN

Dr. Norman C. Wetzel, associate professor of pediatrics, Western Reserve University School of Medicine, Cleveland, spoke on "Assessing the Physical Fitness in Children", at a meeting of the Lorain County Medical Society, January 11, at Lorain.

Officers of the society for 1944 are: Dr. Hudson F. Ross, Lorain, president; Dr. Stanley J. Birkbeck, Elyria, vice-president; Dr. L. H. Trufant, Oberlin, secretary-treasurer; Dr. Geo. D. Nicholas, Elyria, chairman, Legislative Committee; Dr. Trufant, chairman, Committee on War Participation; Dr. Geo. M. Blank, Lorain, chairman, Committee on Industrial Health; Dr. John H. Nichols, Oberlin, chairman, Committee on Recreation and Physical Fitness.—L. H. Trufant, M.D., secretary.

WAYNE

The Wayne County Medical Society has elected the following officers for 1944: Dr. Jean S. Douglas, Wooster, president; Dr. Eva G. Cutright, Wooster, vice-president; Dr. R. C. Paul, Wooster, secretary-treasurer; Dr. Geo. H. Irvin, Orrville, chairman, Legislative Committee; Dr. Paul, chairman, Committee on War Participation.—R. C. Paul, M.D., secretary.

Woman's Auxiliary News

BELMONT

Fourteen members of the Woman's Auxiliary to the Belmont County Medical Society met at the McClure Hotel, Wheeling, W. Va., December 9, for their Christmas luncheon. This was followed by a short business meeting, election of officers and bridge. New officers are: Mrs. C. J. Holley, Bridgeport, president; Mrs. L. L. Liggett, vice-president, and Mrs. B. C. Diefenbach, Martins Ferry, secretary-treasurer. The auxiliary donated $10 to a fund for the purchase of Christmas boxes for patients at the Fletcher General Hospital, Cambridge.

STARK

The annual Christmas tea of the Woman's Auxiliary to the Stark County Medical Society was held at the residence of Mrs. J. H. Bahrenburg, Canton, with 70 members and guests present.

ROSS

"The Golden Age" was the topic of a talk by Mrs. Walter S. Barrett, guest speaker at a meeting of the Woman's Auxiliary to the Ross County Academy of Medicine, January 6, at Chillicothe.



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Initiates into fellowship in the American College of Surgeons during 1943 included the following Ohioans: Dr. Ira A. Abrahamson, Major Nicholas J. Giannestras, Dr. Vinton E. Siler, Cincinnati; Dr. Edward V. Arbaugh, Jr., Martins Ferry; Capt. Frederick P. Berlin, Wapakoneta; Dr. Lawrence N. Atlas, Capt. William F. Boukalik, Dr. W. James Gardner, Dr. William E. Mishler, Lt. Joseph C. Placak, Jr., U.S.N.R., Dr. Arnold F. Sydow, Dr. Charles I. Thomas, Cleveland; Dr. Richard I. Brashear, Dr. Francis W. Davis, Dr. Clyde W. Dawson, Dr. Karl P. Klassen, Dr. Charles W. Pavey, Capt. Cyril T. Surington, Dr. Robert E. S. Young, Capt. Richard W. Zollinger, Columbus; Dr. Wendell T. Bucher, Dr. Gerald W. Quinn, Akron; Dr. Henry P. Koehler, Findlay; Dr. Albert E. Weinstein, Steubenville; Capt. John R. Rohrbaugh, Massillon; Dr. Otto A. Vornholt, Gallipolis; Capt. Richard Hotz, Capt. Aaron D. Vogelsang, Toledo.

Commander Lapman Ill

The Directing Board, Procurement and Assignment Service, War Manpower Commission, has announced that due to the serious illness of Commander M. E. Lapham, which will keep him away from his duties as executive officer for an indefinite time, the Board has appointed Dr. Paul C. Barton as acting executive officer. Dr. Barton has been serving as assistant executive officer during the past year.

New Adoption Law in Effect

Ohio statutes pertaining to adoption as revised last Spring by the Ohio General Assembly (H.B. 279) become effective January 1, 1944. Because a physician is frequently a vital participant in such placement and adoption procedures, a complete analysis of the new law was published in the October, 1943, issue of *The Ohio State Medical Journal*, pages 947-950. Additional information can be obtained from local probate and juvenile courts, certified child-placement organizations or the Division of Social Administration, State Department of Public Welfare, Columbus.

Coming Meetings

Ohio State Medical Association, Columbus, May 2-4.

American Medical Association, Chicago, June 12-16.

Annual Congress on Medical Education and Licensure, Chicago, Feb. 14-15.

Annual Congress on Industrial Health, Chicago, Feb. 15-16.

National Conference on Medical Service, Chicago, Feb. 13.

Northern Tri-State Medical Association, Toledo, April 11.

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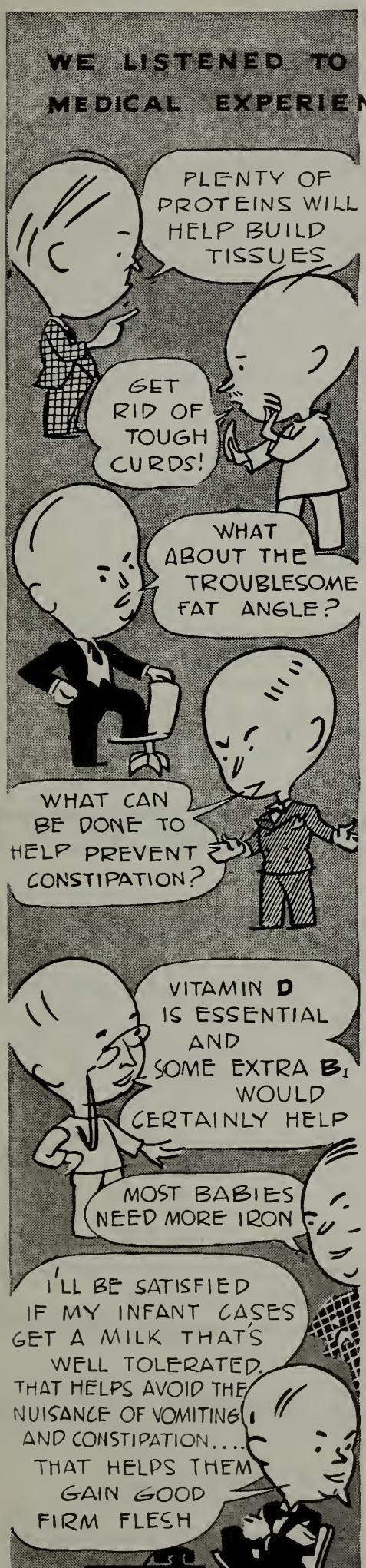
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News Notes

Chardon—Dr. Lucy Stone Hertzog spoke against Socialized Medicine and the Wagner-Murray-Dingell bill at a meeting of the Burton Chamber of Commerce.

Cleveland—Dr. Louis J. Karnosh discussed "War Neuroses" at a meeting of Sigma Xi.

Columbus—Dr. Jonathan Forman spoke on "Making the Best of the Food Situation" at a meeting of the Westerville branch of the American Association of University Women. Another recent address by Dr. Forman was on the Wagner-Murray-Dingell bill at a meeting of the Columbus Life Agency Cashier's Association.

Dayton—Dr. P. H. Kilbourne has been named chief of staff of Miami Valley Hospital.

Dover—Dr. D. W. Shumaker spoke on "Socialized Medicine" at a meeting of the New Philadelphia Kiwanis Club.

Greenfield—The Rotary Club went on record against the Wagner Bill after hearing an address by Dr. C. H. Skeen.

Hillsboro—The Wagner-Murray-Dingell bill was discussed by Dr. L. Howard Schriver, Cincinnati, President-Elect of the Ohio State Medical Association, and Dr. E. O. Swartz, First District Councilor, at a public meeting in the High School sponsored by the local Women's Clubs. A half-hour of music by the High School band preceded the discussion.

Hollansburg—Dr. G. W. Harley, who has been practicing medicine for 52 years, recently celebrated his 84th birthday.

Milford—The Wagner-Murray-Dingell bill was discussed by Dr. E. O. Swartz, Cincinnati, First District Councilor for the Ohio State Medical Association, at a meeting of the Kiwanis Club.

Mt. Vernon—Dr. George T. Harding, Columbus, Tenth District Councilor of the Ohio State Medical Association, spoke on the Wagner-Murray-Dingell bill at a meeting of the Lions Club, at which members of the Knox County Medical Society were guests.

Sandusky—Dr. C. R. Knoble was re-elected president and Dr. J. D. Parker, vice-president, of the Sandusky Board of Education. They have held the offices for 21 years and have been board members for 25 years.

Toledo—Dr. Walter H. Hartung is the new city health director. He succeeds Dr. Earl E. Kleinschmidt who resigned in January, and is now associated with the U. S. Public Health Service.

Wilmington—Dr. Kelley Hale gave an address on "Rock Formations" at a meeting of the Rotary Club.

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The Physician's Bookshelf

A Doctor's Daily Diary, Vol. II, by Louis R. Effler, M.D. *(Privately printed, Toledo, Ohio)*, is a further series of daily activities over a period of six months in 1942. The appearance of this volume and the reception of the first volume goes to prove how much we all are concerned with the other fellow's sickness—partly as disinterested spectators but mostly as interested actors in the drama of Life, which may touch us in some way or another at some time in the future.

Barometric Pressure. Researches in Experimental Physiology, by Paul Bert, translated from the French by Mary Alice Hitchcock and Fred A. Hitchcock, of Ohio State University ($9.00. *College Book Store, Columbus, Ohio).* This classic study which settled conclusively that mountain sickness was due to diminution of oxygen pressure has been made available to English speaking investigators in the field of aviation medicine. It is a most timely and worth while contribution.

Personal and Community Health, by C. R. Turner, D.P.H. ($3.50. 7th edition. *C. V. Mosby Company, St. Louis)* is a new edition of the well known University text bringing it up to date. Its success speaks for the quality in both fields which it covers.

Stay Young and Live. Common Sense About Health in War Time, by J. Clarence Funk, Sc.D. ($1.75. *The Dietz Press, Richmond, Va.)* is an inspirational volume by the Director of Education, Virginia State Department of Health. The author has demonstrated again his ability to translate scientific findings into practical instruction for the average citizen. Health after forty is an achievement. It means purposeful struggle. It would be a better world if everyone could but read this book.

Nutritional Deficiencies, by John B. Youmans, M.D. ($5.00. 2nd edition. *J. B. Lippincott Company, Phiadelphia)* represents the rapid progress which has greatly increased our understanding of the clinical manifestations of nutritional deficiencies. The author again sticks closely to the facts that should be readily available for the physician. This new edition includes changes in the eye in vitamin A deficiency, vascularization of the cornea in relation to riboflavin deficiency, diagnostic methods and tabular summaries.

Microscopic Technique in Biology and Medicine, by E. V. Cowdry ($4.00. *Williams and Wilkins Company, Baltimore, Md.)* is a concise new book by a great authority.

Life is Too Short, by C. Kay-Scott (Dr. Frederick Creighton Wellman) ($3.50. *J. B. Lippincott Company, Philadelphia, Pa.)* proves the truth of the title. A life full of romance, of science, of medicine, of painting, of mining, of writing, of business, of farming and philosophy. Africa, South America and North America. A good book for a cold winter evening.

Principles and Practices of Rehabilitation, by John Eisele Davis ($3.00. *A. S. Barnes and Company New York City)* outlines the author's great experience. Such books become of increasing value as the period of war excitement reaches its climax. The author clearly sets forth his viewpoint which is that the individual is primary and his wants, interests, needs, and capacities, are the building stones with which to build the rehabilitated person. Most of us physicians should study this small volume.

Body Poise, by Walter Truslow ($4.50. *William and Wilkin Company, Baltimore, Md.)* is presented as essential to physical fitness. This fact is presented in broad prospectus.

Diagnosis of Uterine Cancer by the Vaginal Smear, by George N. Papenicolaou, M.D., and Herbert F. Traut, M.D. ($5.00. *Commonwealth Fund, New York City)* is an attempt to establish an early diagnosis of uterine cancer. The description and records of this book show the method recommended. The authors, however, insist that it shall be used as an accessory procedure along with biopsy, currettage, and other methods. The detailed descriptions, the straightforward presentation of the findings with the great number of good drawings and photomicrographs make the work most valuable to clinicians.



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Do You Know - - -

Mrs. Lillie Cooper, Findlay, was appointed a member of the State Public Health Council by Governor John W. Bricker, succeeding Mrs. Alice Powers LaCoste, Toledo, and will serve a term expiring June 30, 1949.

* * *

The 1944 session of the National Conference on Medical Service will be held Sunday, February 13, at the Palmer House, Chicago. Details of the program may be obtained by addressing the president, Dr. W. L. Burnap, Fergus Falls, Minn., or the secretary, Dr. C. L. Palmer, 8102 Jenkins Arcade, Pittsburgh.

* * *

During March the American Red Cross will raise its 1944 War Fund. A goal of $200,000,000 has been set. This must be met if the Red Cross is to continue its work on an undiminished scale.

* * *

According to State Director of Health R. H. Markwith, Ohio marriages were 24 per cent less in 1943 than in 1942. Pre-marital blood tests indicated there were 60,129 marriages last year, compared with 84,265 in 1942.

* * *

Dr. Sterling H. Ashmun, Dayton, has been appointed a member of the U. S. Children's Bureau Advisory Committee on Maternal and Child Health Services. He and four other physicians were appointed in response to the resolution adopted by the Advisory Committee October 21, 1943, requesting that the committee be enlarged by the appointment of at least five physicians actively engaged in the private practice of medicine.

* * *

Political control through socialized medicine will lower professional standards and encourage young men to seek the favor of their superiors for personal advancement rather than through professional proficiency, said Dr. Carll Mundy at a Toledo YMCA Town Meeting. A past-president of the Toledo Academy of Medicine, Dr. Mundy represented the medical profession in a discussion of the Wagner-Murray-Dingell bill. His opponent was Oliver J. Pecord, editor of the *Toledo Union Journal*.

* * *

A timely communication to the Editor of *The Journal of the A.M.A.* on "Hazards of Exposure to Glass Wool, Glass Frit or Foam Glass", by Dr. Barney J. Hein, Toledo, Chairman of the Committee on Industrial Health of the Ohio State Medical Association, appears on pages 187-8 of the Jan. 15, 1944, issue.

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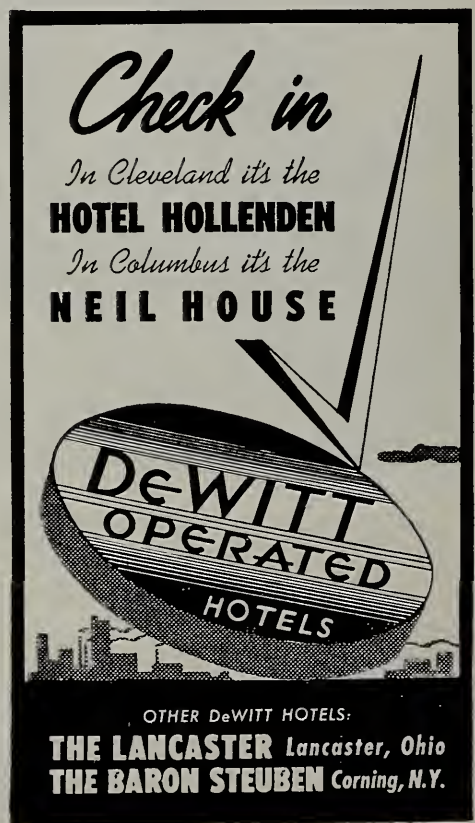
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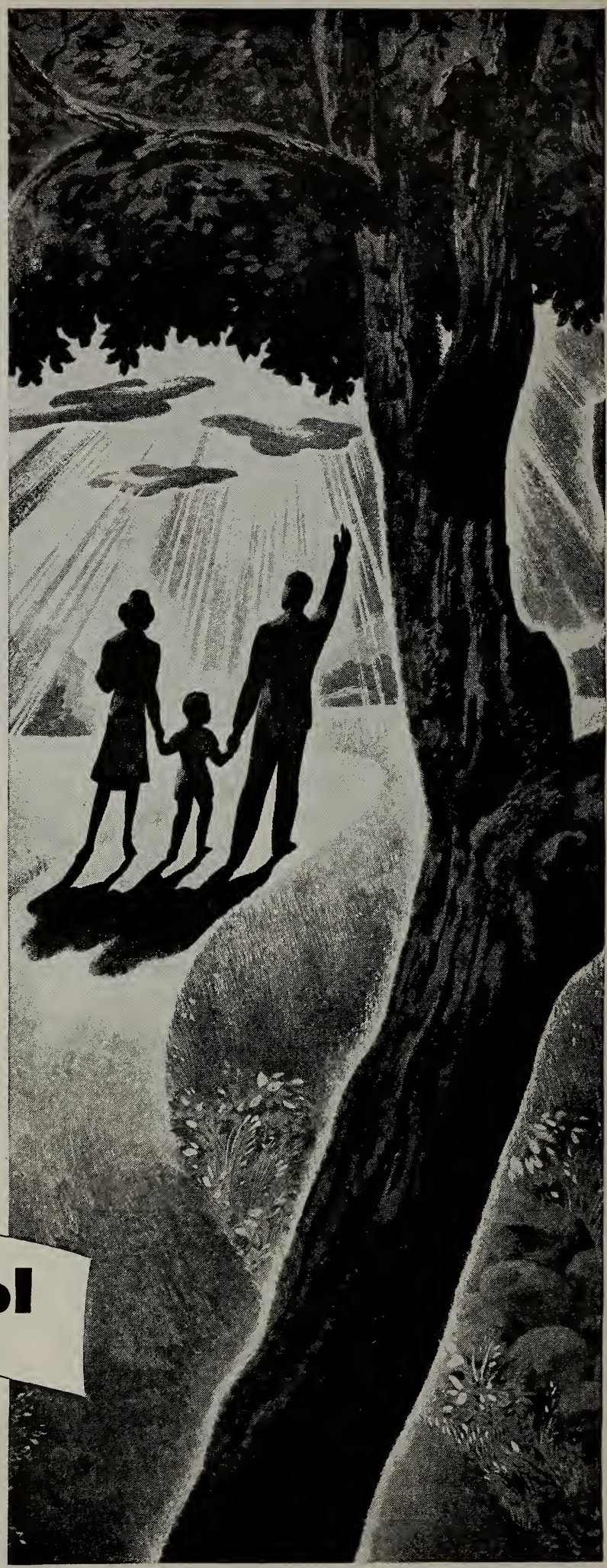
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The Ohio State Medical Journal

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Vol. 40 March, 1944 No. 3

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.* GEORGE H. SAVILLE, *News Editor*

The Problem of Protein Intake In Wartime

MARTHA KOEHNE, B.A., M.A., Ph.D.

PROTEIN has been recognized as the chief constituent of the muscles of all actively functioning tissues since 1838, at which time Mulder gave such substances the name *protein*, a word derived from the Greek verb meaning "to take the first place". In addition to carbon, hydrogen and oxygen, which are the elements found in carbohydrates and fats, proteins contain nitrogen as their characteristic element, and sulfur. Proteins are essential constituents of all plant and animal life and cell structure. No form of life is possible in the absence of protein. Proteins play many roles in the body that have only been recognized recently. Serum proteins play an important part in the maintenance of the water balance of the body. Many of the familiar enzymes are protein in nature. A number of hormones are either proteins or are derived from proteins. Anti-bodies and other substances associated with immunological and anti-toxic processes are known now to be proteins. Some of the substances known to produce specific pathological changes associated with virus diseases are also known to be protein in nature.

The Author

● Miss Koehne, Columbus, Ohio, (Ph.D., Yale University) is nutritionist, Ohio Department of Health.

PROTEIN IN ANIMAL FOODS

Plants, including yeasts, molds and bacteria, can synthesize their own characteristic types of protein from very simple materials or elements found in soil and air, whereas animals are dependent upon digestion products of their food proteins for the building stones out of which they make their own characteristic types of body protein. Therefore the food animals eat must contain ready-made protein or its digestion products.

The efficiency with which any given food protein can be converted by animals into body protein depends upon the kind of building stones of which it is composed and into which it is broken up in digestion, as well as upon the proportions in which these different building stones are present in the digestion products. These building stones are called amino acids of which there are now known to be twenty-two. Lewis[1] quotes Karl Thomas as stating in 1929: "What we need to know is: 1. Which amino acids must be present in the food, 2. How much we require of each, 3. And to what purpose." Lewis continues by saying: "Today, after more than a decade of intense interest and research in protein metabolism, these questions still epitomize the problem of the role of proteins in nutrition." Rose, at the University of Illinois, has demonstrated that ten only of the twenty-two known amino acids are essential for the growth of white rats, such animals being apparently able to synthesize the remaining twelve. Recently Rose and associates have been conducting studies designed to show which amino acids are essential for maintenance of nitrogen equilibrium in adult human subjects.[2,3,4]

EIGHT ESSENTIAL ACIDS

These studies have demonstrated that the following eight amino acids are essential for such purpose: leucine, isoleucine, valine, phenylalanine, methionine, threonine, lysine and tryptophane. Histidine and arginine, which are the other two that are essential for growth in rats, are not essential for maintenance of nitrogen equilibrium in man. Subsequent experiments may, however, show them to be essential for growth of children.

Observations of Holt, Albanese and co-workers[6,7,8] agree with the findings of Rose. Holt and colleagues[5] have shown arginine to be essential for the production of spermatozoa in men. Cystine and methionine are the only amino acids that contain sulfur. Cystine can be synthesized in the presence of methionine but the reverse is not possible.

Whipple and colleagues at the University of Rochester[9] showed that the ten amino acids essential for rat growth were equally effective in regeneration of plasma proteins in dogs rendered hypoproteinemic by plasmapheresis. This was true whether the amino acids were given orally or intravenously. When any one or more of the ten were withdrawn there was less favorable response,—either plasma protein production lagged or nitrogen balance became strongly negative with impaired appetite and disturbed clinical state.

Shohl and Blackfan[10] found it possible to nourish infants successfully when the sole source of protein was either a mixture of crystalline amino acids made up according to Rose's formula for rats, or an enzymatic digest of casein. Altshuler and colleagues[11] demonstrated that a suitable mixture of amino acids can be administered intravenously or even into the bone marrow, with successful results, in a wide variety of preoperative and postoperative conditions where oral administration of protein-rich foods is impossible.

PROTEIN REQUIREMENT

Table I is adapted from the recommendations of the Food and Nutrition Board of the National Research Council.[12] Calories are included as well as protein requirements because it is generally accepted that, when body stores of protein have to be drawn upon to supply energy, the need for dietary protein is increased. Food carbohydrate is more efficient than is food or body fat in preventing body protein from being used as a significant source of energy. The figures in Table I are to be taken as averages. Caloric requirement will vary greatly with the activity of the individual as well as with his body build and size. Protein requirement is more accurately expressed as grams per pound or per kilogram normal body weight. (2.2 pounds equal 1 kilogram.)

These protein allowances are generous enough to provide a sufficient margin of safety beyond actual physiological need. If one studies the figures in the right hand column, it is evident that growth and rate of growth greatly increase the physiological need for protein calculated in terms of requirement per unit of body weight. Other general states associated with increased need for protein are conditions involving increased loss of protein or nitrogen products from the body. These include the latter half of pregnancy; lactation; acute or chronic blood loss from whatever cause; heavy loss of serum protein in urine, as in nephrosis; extensive burns associated with heavy loss of serous exudate, etc. One case is on record[13] of a patient with burns covering 55 per cent of his body surface, who required 6000 grams of protein over that indicated by nitrogen balance studies before improvement in his condition began. As much as 1700 to 1800 grams of protein were administered to this patient per week, as amino acids given parenterally, and as protein by intubation and by mouth, together with a total of 120 liters of blood plasma given throughout his recovery. Diet could not have provided these astonishing amounts of protein.

Contrary to popular belief, hard physical work does not increase body need for protein, but does increase caloric requirements. (Table 1.) However, inasmuch as protein is found in all natural foods, a diet high enough in calories to meet the energy needs of a lumberman or a football player, for example, will contain more protein than is indicated in Table 1 as necessary. Certainly a high caloric diet containing chiefly starchy and sweet food would not be satisfying to the appetite of hard working persons.

SERIES OF STUDIES

Stare and Thorn of the Harvard Fatigue Laboratory[14] reported studies of three groups of young men, eight to a group, who subsisted for two months on three levels of protein intake. One group had its customary diet providing 100 gm. protein per day, 60 per cent of which was animal protein; another group was limited to 50 gm. protein per day, only 5 gm. of which was animal protein (milk); the third group had a high protein diet of approximately 160 gm. daily, most of which was animal protein. Blood examinations were made periodically, subjective symptoms were carefully studied, and observations were made on the comparative readiness to fatigue of the men when doing hard physical work. No differences were noted in the three groups. While one might conclude from this study that a diet can safely be low in protein even when this protein is 90 per cent from plant sources, provided adequate calories are supplied and essential vitamins, the authors state: "In dealing with the health of the public, it is, no doubt, safer to rely on a protein level of at least 70 gm. per day for the average adult man and 60 gm. per day for the average adult woman as recommended by the Food and Nutrition Board." (Table 1.) One wonders if the previous good state of protein nutrition of the men (who had all been on diets similar to that of the group receiving 100 gm. protein per day), enabled them to stand the low protein diet more successfully for two months than would have been possible had their bodies been in a low state of protein nutrition at the beginning of the study.

Several recent studies[15,16] show the advantage

TABLE 1

	Caloric Requirement	Protein Requirement	
		Total grams per day	Grams per kilogram per day
Man: sedentary	2500	70	1.0
mod. active	3000	70	1.0
very active	4500	70	1.0
Woman: sedentary	2100	60	1.0
mod. active	2500	60	1.0
very active	3000	60	1.0
Pregnancy, latter half	2500	85	1.25 to 1.5
Lactation	3000	100	1.5 to 2.0
Children up to 12 years*			
Under 1 year	100 per kgm.		3.0 to 4.0
1 to 3 years	1200	40	2.5 to 3.0
4 to 6 years	1600	50	2.25 to 3.0
7 to 9 years	2000	60	2.0 to 2.5
10 to 12 years	2500	70	1.75 to 2.0
Children over 12 years*			
Girls: 13 to 15 years	2800	80	1.5 to 1.75
16 to 20 years	2400	75	1.0 to 1.75
Boys: 13 to 15 years	3200	85	1.5 to 1.75
16 to 20 years	3800	100	1.25 to 1.5

* The figures represent allowances for the mid-year in the range indicated.

of liberal protein diets in producing more effective utilization and even synthesis of riboflavin and niacin, and more efficient utilization of dietary calcium and magnesium.

LOW PROTEIN DIETS

There is increasing argument that more danger lies in long-continued use of insufficient amounts of protein than in eating food containing more protein than is necessary (Table 1). The danger is three-fold:

1. The foods that provide most of the protein in such diets are cereals. Since most of the cereal food eaten is usually highly milled, such foods may also be deficient in minerals and vitamins, unless enriched.
2. The amino acid make-up of cereal proteins does not conform, as far as the ten essential amino acids are concerned, with the amino acid pattern of proteins of animal foods. Therefore nitrogen equilibrium could not be maintained as successfully over long periods of time, nor could growth be as successful, even if the amounts indicated in Table 1 could be ingested.
3. Body tissue would be drawn upon to make good the amino acid deficiencies of the protein intake and the percentage of serum proteins might decrease gradually.

There are conditions where a low protein diet must be prescribed by the physician. These conditions include acute nephritis not associated with heavy loss of albumin in the urine, but where the non-protein-nitrogen of the blood is high; diseases of the heart or circulation that cause impairment of the ability of the kidneys to excrete urea.

Whenever such diets must be administered, they should not be continued longer than is absolutely necessary. It is also essential that half or more of the protein come from animal sources such as milk, eggs and meat. This will insure the least waste of body tissue protein provided the diet contains plenty of calories from simple sugars, fruits, etc., fat intake being kept reasonably low. Protein intake should not be less than one-half to two-thirds grams per kilogram normal weight. If dietary protein is kept too low or if it contains little or no animal protein, body tissues will be metabolized to make good the deficit. Wastage of body protein increases non-protein-nitrogen in the blood just as does metabolism of food products, so defeats the purpose of the low protein diet. Most patients with heart or kidney disorders can safely eat a normal protein diet provided the foods are selected to meet the ability of the patient to digest and assimilate them successfully.

PART GLOBULIN PLAYS

Cannon at the University of Chicago[17,18,19,20] has produced evidence that strongly supports his contention that low serum protein is indicative of low body reserves of protein and that such conditions are the chief causative factor in increasing susceptibility to infections. Antibodies are formed by the action of specific antigens on globulin. That globulin plays a very important role in the body is evidenced by the fact that its concentration in the blood is quite constant in contrast to that of serum albumin. Cannon's thesis is that the ability of the body to synthesize globulin is the secret of the problem of specific immunity to infections. Cannon believes that starvation or severe blood loss may lead to withdrawal of antibody-globulin reserves from cells

TABLE 2
Sample Diet for One Day for Moderately Active Man

	Sizes of Portion		Calories	Protein (gm.)
Breakfast				
Citrus fruit juice	3½	ounces	50	0.9
Oatmeal, cooked	½	cup	119	4.3
milk	⅓	cup	55	2.7
Toast, enriched white	2	slices	160	5.2
butter*	1	tablespoonful	100	0.1
Coffee	1	cup	-----	-----
top milk	1	tablespoonful	25	0.4
Sugar (coffee and cereal)	2	rounded tsp.	80	-----
Meal total			589	13.6
Lunch				
Scrambled egg	2	eggs	140	11.6
Waldorf salad: lettuce	1	med. leaf	2	0.1
apple	1	small	48	0.2
celery	¼	cup, cut	3	0.1
Eng. walnuts	4	to 6 meats	71	1.5
mayonnaise	1	tablespoonful	100	-----
Bread, 100% whole wheat	2	slices	160	5.8
butter* (bread and egg)	1	tablespoonful	100	0.1
Milk	8	ounces	164	8.2
Prunes	4	med., with juice	150	1.1
Meat total			938	28.7
Dinner				
Baked potato	1	medium	150	3.0
Roast veal	1	sl. 2x2¾x⅛"	180	19.0
Green beans	½	cup	42	2.4
Raw carrot strips	5	to 6 strips	5	0.1
Soybean bread**	2	slices	175	7.7
butter* (beans, bread)	1½	tablespoonfuls	150	0.1
Pumpkin pie	1/6	of 9" pie	275	8.3
Coffee, black	1	cup		-----
sugar (optional)	1	rounded tsp.	40	-----
Meal total			1017	40.6
Grand total for day			2544	82.9
Day's requirement for average adult moderate activity (Table 1)—man			3000	70
		woman	2500	60
Proportional amount of day's intake of calories and protein in above diet, furnished by:			%	%
bread and cereals			27.	28.
egg and meat			12.1	37.4
milk			12.4	21.8
fruits and vegetables			19.	10.

*Butter may be either butter or fortified margarine.
**Recipe for soybean bread: (makes two 1½ pound loaves).
Milk (skim or whole) 2½ cups. Scald and cool to lukewarm. Add 2 Tbs. sugar and 1 or 2 cakes yeast (plain or high-vitamin yeast). Let stand one-half hour, then add 2 Tbs. fat, melted.
Mix together thoroughly 1 cup soybean flour, 2 cups whole wheat flour and 4 cups enriched white flour, with 1 Tbs. salt. Combine with milk mixture, turn out on bread board and knead well. Let rise in covered greased bowl till double in bulk. Repeat kneading and rising process three times. Last time cut in two and place in greased breadpans. Again let rise above top of pan. Bake at 350 to 375 degrees for 45 to 50 minutes.

concerned with antibody production. Cannon's observations on patients have shown a very close correlation between low serum proteins and long-continued use of low protein diets with the occurrence of terminal infections.

Everyone is familiar with the success of the modern method of liberal feeding of typhoid patients in increasing their chances for recovery, in contrast with the old starvation method. Coburn and Moore[21] believe that protein deficiency is probably the most significant factor in making rheumatic fever a disease primarily of the poorly nourished child. Sako[22] found that additions of protein to the diet of white rats greatly increased their resistance to lethal doses of a virulent strain of pneumococci.

Weech[23] classes the following proteins in decreasing order of effectiveness in serum albumin synthesis: 1. lactalbumin and beef serum, 2. colostrum and egg, 3. milk, beef muscle and liver, casein, 4. wheat gluten and gelatin Whipple[24] concludes: "We may now attempt to formulate briflly our understanding of plasma protein metabolism. Food proteins yield the amino acids

absorbed from the intestinal tract and the amino acids are synthesized in the liver cells (and elsewhere) into plasma proteins. These plasma proteins (and amino acids) supply the protein requirement of the body cells. Normally there is a considerable reserve of plasma protein-forming material (1 to 5 times the circulating mass) which reserve may be reduced by fasting, low protein diet or plasma depletion. This depletion of protein reserves lowers the body resistance to infection and intoxication. These body protein stores, protein production and protein wear and tear, are in a nicely balanced or steady state—a dynamic equilibrium. These proteins can pass readily from plasma into cells and the reverse, without loss of nitrogen. . . . Hemoglobin in its production may draw upon the plasma protein but hemoglobin stands apart in the protein economy and does not contribute freely to the protein pool. On the other hand the body guards jealously the fabrication of hemoglobin and given a real need for both plasma protein and hemoglobin, the protein flow favors hemoglobin, which, under these circumstances always is produced in more abundance than the plasma proteins."

Many have observed the common association of anemia with protein deficiency.[25] Elman[26] calls attention to the common occurrence of protein deficiency in surgical cases and to the need for building up the protein reserves. He says: "Many formerly mysterious instances of failure of wounds to heal, disruption of incisions", etc., "are now realized to be manifestations of a deficiency in protein" as evidenced by low serum albumin values. The association of edema with protein starvation and hypoproteinemia was first recognized toward the close of World War I. There have been numerous reports of such cases in the intervening years.

Table 2 gives types of food regarded as essential in a well-selected diet and in amounts needed by a moderately active man (Table 1). Only calories and protein have been calculated but minerals and vitamins would be equally satisfactorily supplied. Extra calories could be taken as jam, jelly, etc.

According to the data presented by Block, [28] during the period 1937 to 1941 the typical American diet provided 90 gm. protein per day, of which 21 per cent came from dairy products, 38 per cent from meat, fish and poultry, and 8 per cent from eggs—totalling 67 per cent from animal sources. Plant foods furnished the balance—6 per cent from legumes and nuts and 27 per cent from cereal foods. The sample diet shown in Table 2 provides approximately 60 per cent of the protein from animal sources.

Beach and colleagues[27] report the amounts of the ten amino acids that are essential to animals, which are found in meat, variety meats, poultry, fish, shellfish, frog and turtle. They found that the proportions of these acids in voluntary muscles of the above species were remarkably similar. There was more difference, however, between the proportions found in beef organs and muscle beef, than between the muscles of this wide variety of species. The authors believe their data demonstrate the amino acid pattern to which animal muscle must conform in its synthesis. All such foods may be used interchangeably as human sources of dietary protein. An average serving of meat, variety meat, or most fish weighs 3½ ounces or 100 grams, and contains 15 to 20 grams of protein. It would take varying amounts of other types of food to give this same amount of protein.

Table 3 gives a wide range of choice in selecting dietary protein, keeping in mind, also, that all meats, variety meats (liver, heart, kidney, sweetbreads, etc.), fish, shellfish, game and poultry can be used almost interchangeably. As of January 1, 1944, fresh fish and shellfish, game, poultry, eggs, most variety meats, milk, peanuts, peanut butter and soybeans are not on the rationing list. Poultry and game can be canned under pressure or quick frozen in seasons of plenty to replace rationed meats as needed.

TABLE 3

Table of Equivalents of Protein Content of 1 Serving Meat, Fish or Poultry.

Tuna fish,—3 ounces	(One ounce of dry beans or dry cereal is an average helping.)
Clams,—5½ ounces	Dry peas or beans,—2½ to 3 ounces
Oysters,—7 ounces	Soybeans,—2 ounces
Shrimp,—3½ ounces	Flaked or puffed cereal,—12 to 15 cups
Milk,—16 to 20 ounces	Shredded wheat,—6 biscuits
Hard cheese,—2 to 2½ ounces	Bran,—4 ounces
Cream cheese,—8 to 10 ounces	Oatmeal,—4½ ounces
Cottage cheese,—3½ ounces	Rice,—9 ounces
Eggs,—3 to 3½ eggs	White bread,—7 to 8 slices
Peanuts,—scant ⅗ cup, shelled	Whole wheat bread,—6 slices
Peanut butter,—4 to 5 tablespoonfuls	Soybean bread*—4 to 5 slices
	Wheat germ,—8 tablespoonfuls
	Yeast,—fresh—10 cakes; dry brewer's,—4½ tablespoonfuls

* See recipe, foot of Table 2.

It should be comparatively simple, provided some thought is given to the problem, to plan or choose meals containing an adequate amount of protein within one's ration allowance, and providing at least forty per cent of the protein from animal sources. Cereal proteins provide a less satisfactory amino acid mixture than do animal proteins but there is ample evidence to prove that these deficiencies are adequately supplemented by proteins from milk, meat, eggs, etc. in the rest of the diet.

We must be willing to use other forms of animal protein than the favorite meat cuts to which we were accustomed in pre-rationing days. Also we should learn a variety of ways to use peanut, peanut flour and butter,[29] soybeans and soybean flour and grits,[30] as well as other familiar forms of dry beans and peas, so that they can replace a greater proportion of meat protein than has previously been necessary. It is interesting to compare the protein value of two slices of soybean bread in the dinner menu (Table 2) 7.7 grams, with that of a similar amount of whole wheat bread in the luncheon, 5.8 grams, and of enriched white bread in the breakfast menu, 5.2 grams. Fourteen per cent of the protein in this soybean bread comes from milk, which is an added advantage.

MEAT ALTERNATIVES

No one claims that four or five slices of soybean bread or a serving of peanut loaf, will take the place of a serving of roast beef from the standpoint of human satisfaction. However both products are very good to eat. If one cannot have meat, there would be at least a mental and physiological satisfaction in knowing that one's nutrition would not suffer if such alternatives have to be used rather frequently. In an editorial in the Baltimore Sun, November 17, 1943, appears this statement: "The time may come when a charcoal-broiled soybean steak will get the preference over a steak off a steer, but that time still seems a long way off. The mind is amenable, but the stomach remains backward, stubborn, set in its way. 'Excellent' says Mind, full of nutritional facts. 'Even if it was good, I wouldn't like it', replies Belly. That leaves it up to the nutritionists to effect a workable compromise."

Another possible alternative to meat we may be eating before the war is over is a new form of yeast, Tortula utilis.[31] It grows very rapidly. It is estimated that a 10x10x10 ft. vat will produce as much "meat" in a year as 1000 acres of pasturage and with much less manpower. The new yeast has been cross-bred for a variety of flavors—meaty, nutty or celery-like. The dried product that will be marketed as a food will have no leavening power. It will contain over 50 per cent protein and will be very rich in B-complex vitamins. (The figures given for yeast at the end of Table 3 are for the old familiar brewer's yeast, not for this new form that is not yet on the retail market.)

Readers who are interested in more bizarre alternatives to meat in wartime, will be fascinated at reading the article by Wilder and Keys,[32] keeping in mind that there are people living in this world who eat these very unusual forms of protein. Realization that the U. S. Department of Agriculture is not yet expecting us to eat these foods in place of meat may make some, who agree with the editor of the *Baltimore Sun*, more willing to eat peanut and soybean products and even the new yeast meat with more cheerfulness.

The problem of securing adequate ration points for patients who must be on special diets has recently been solved by OPA,[33] with the help of the sub-committee on medical food requirements of the National Research Council. Many of the special diets listed require extra meat allowances. Authority for certification to rationing boards is restricted to persons licensed to practice medicine and surgery. Certification must be renewed once a year or more frequently in specified cases. Maximum allowances are indicated. For valuable information on special rationing problems in pregnancy and in infant feeding, readers are referred to the report by Deitrick and Clouse.[34]

CERTAIN TRENDS IN FOOD PRODUCTION AND DEMAND

Demands on the Allied Nations for food to feed the starving people of Europe will increase as soon as each conquered nation is released from Nazi control. That these people be fed is absolutely essential to prevent utter chaos and to make possible a rapid return to a semblance at least of sane sound government. Plans being made for this work as a result of the Inter-allied Food Conference in Warm Springs, Virginia, call for only the simplest possible diet for these unfortunate people. No effort will be made to furnish even what we would call a minimum adequate diet. Insofar as possible, however, foods will be supplied that have been staple, inexpensive foods in each nation. The greatest need will be for breadstuffs and for seed and simple farm machinery.

Because of the world-wide need for the food that can be produced in those countries that are still safe from the direct ravages of war, it will be necessary for governmental agencies in those countries to plan carefully for maximum production and efficient utilization of those foods that will best meet world needs. Unfortunately, valuable as meats are nutritionally as sources of excellent quality protein, iron, and B-complex vitamins, and as much enjoyment as we all get out of eating them, they are extravagant to produce in years of world-wide food scarcity.

Some interesting figures were given by Thorn-

dike recently in *Life*,[35] that illustrate this very graphically. An acre of farm land can produce 44.3 bushels of corn which could sustain a human life, though in an unsatisfactory manner, for 954 days. If this same amount of corn was fed to hogs, however, only 308 pounds of pork would be produced, which would last only 167 days as food for a man, but he would be better nourished than if he ate the corn directly. If the acre was used to feed beef cattle, only 94 pounds of beef would be produced. This would last only 16 days as human food. If the acre was used to feed hens, this would produce 239 pounds of eggs which would sustain a human life for 93 days. In emergency times, grains, therefore, go much farther in nourishing human beings than if a large part of the grain crop of a nation is used in livestock production. This country may have to decrease production of meat from those types of animals that depend largely on grains for their diet.

Dairy cattle give much more to human beings in return for what they eat than do strictly meat-producing animals. Considerable manpower would be saved, in the dairy business, if the quality of dairy cows could be steadily improved. In this same issue of *Life* is the statement that at present it requires 750 million acres to feed our 235 million dairy cows that yield an average of ¾ pint of milk per person per day. If, however, all the dairy cows were prize animals, it would require 1,450 million acres to feed the 40 million cows that would be required to produce one quart of milk per person per day. India has 30 per cent of the world's cows but produces only 10 per cent of the world's milk.

If everyone in the world were to have enough of all the valuable foods required to sustain excellent nutrition, the farmers in the world would have to produce 50 per cent more cereals, 90 per cent more meat, 125 per cent more milk and dairy products, 125 per cent more vegetable oils and 300 per cent more fruits and vegetables. The common man would have to have, in addition, the income to enable him to buy these foods. With manpower and equipment shortages facing our farmers for at least one more year, Victory Gardens will be even more of a necessity in 1944 than in 1943. Raise your own soybeans. They are excellent when eaten green, and can be used in a variety of ways as mature beans.

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Malaria

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THE subject of malaria seems far away from a beautiful city like Portland, but it is the number one disease which has presented itself in all of our tropical theaters of militay activity. It has been said by one of our eminent authorities on malaria that we are going to beat the Japs, but it is conceivable that malaria may get there first. In other words, malaria may win the Pacific War. This is the serious problem which we have to confront.

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ETIOLOGY

What is malaria? Malaria is an infectious disease transmitted to susceptible warm-blooded animals by certain species of mosquitoes, and is characterized by more or less rhythmic episodes of chills and fever, with remissions. Almost invariably after malaria has assumed clinical proportions, a pronounced anemia is established.

Malaria is produced by certain protozoan organisms belonging the genus **Plasmodium.** Therefore it is redundant to speak of a malaria plasmodium, because when we say "plasmodium", we mean the organism producing malaria. But malaria is not peculiar to human beings. There are a few species of malaria parasites which are found in lizards, several species which are found in birds, and many species in mammals, including four which are peculiar to man. Insofar as we know, no other mammals, birds or any other animal except certain mosquitoes harbor these four species of malaria parasites which cause disease in man.

The three most common species parasitizing man are, respectively: (1) **Plasmodium vivax,** producing vivaxmalaria or so-called benign tertian malaria which is characterized by a repetition of the chills and fever typically every forty-eight hours, (2) **Plasmodium malariae,** the so-called quartan type, which is characterized by a repetition of chills and fever every seventy-two hours, and (3) **Plasmodium falciparum,** producing falciparum malaria, the so-called tropical or malignant malaria, or, as we choose to call it in the United States and in the Mediterranean basin, estivoautumnal malaria, because it is most prevalent in the late summer and early fall. A fourth species, **Plasmodium ovale,** is also a well recognized parasite of man, but is limited in distribution almost exclusively to the central east portion of Africa, essentially in the same highland area where the East African type of trypanosomiasis is prevalent.

HISTORY OF MALARIA

In the old Chinese medical annals there was evidence that the Chinese people recognized malaria and distinguished the three common types, tertian, quartan and malignant. In ancient Greece this same clinical distinction was made. And yet, coming down through the centuries, in spite of the fact that malaria took its heavy toll year by year and century by century, the individual who first observed malaria parasites in human blood was Alphonse Laveran 1880).

Laveran was a young French medical officer working in Algeria, and had numbers of soldiers who suffered from this infection. He had available only microscopes with low and high dry lens magnifications. He had no satisfactory stains He observed the living parasites in wet blood films under his high dry lenses. Great honor is due to Laveran for first observing and describing the malaria parasites. This work was rather slowly confirmed, following the discovery in 1880, but by the end of the nineteenth century a great deal of progress had been made.

Ronald Ross was the next important contributor to our knowledge of malaria. He was a young medical officer in the Indian Medical Service and at first, in the early 1890's, was in a heavy malarious area, but when he had gotten experiments under way in order to determine whether mosquitoes were or were not the transmitters of malaria from man to man, he was moved to an essentially nonmalarious area. However, month by month, he was inspired by letters from the great Patrick Manson, who suggested to him that he study bird malaria. And so, spurred on by Manson, Ross studied bird malaria and discovered the part which mosquitoes play in the life cycle. He found that this infection was transmitted by Culex, the ordinary house mosquito, and published his findings in 1895-1897, demonstrating that the life cycle involved this mosquito.

Meanwhile, in Italy, Grassi, a distinguished

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biologist, beginning his work in 1889 and continuing through the 1890's, together with his clinical colleagues, discovered the life cycle of the human malaria parasites and in Italy found that there were three of these species, the three prevalent types which have already been mentioned. High praise is due to Grassi and his colleagues for confirming for human malaria what Ross had originally discovered for avian malaria.

There is one essential difference between human and avian types of malaria, namely, that in man the organism is transmitted by Anopheles mosquitoes, while in birds it is usually carried by Culex mosquitoes.

We should not leave out of the record the great usefulness which quinine has played throughout the centuries in the treatment of malaria. Before Columbus came to the Western Hemisphere, the Incas and other highly developed Amerind peoples used infusions of the bark of chinchona trees to cure, or at least to alleviate, certain remittent fevers which they had. During the sixteenth century, this secret was carried back to Spain and became widely disseminated through the Mediterranean area. Chinchona bark and its more refined product quinine, came to be used extensively as the most important antimalarial drug. It has only been during the last two decades that plasmochin and atabrine have been synthesized and today constitute other valuable antimalarials. Nor should we leave out of the picture the epochal work which has been done in the Panama Canal Zone, in Italy and elsewhere in successful attempts to control malaria in those highly malarious areas.

GEOGRAPHIC DISTRIBUTION OF MALARIA

Let us next look at the present geographic distribution of malaria. On any map showing malarious areas, there are extensive regions of hyperendemicity, where malaria is highly prevalent in the native population. They all occur in warm climates. Moreover, it may be well to point out that all of our theaters of military operations in the tropics lie in such places of high endemicity: the Solomon Islands, New Britain, New Guinea, Northern Australia, and up through the Southwest Pacific to the Philippines and Central China; all this is hyperendemic malarious territory. Furthermore, all of the northern part of South America, most of Central America and the southern part of Mexico are similarly malarious; the central and northern parts of Africa, the Persian Gulf area and India, and particularly east of India leading up to the Burma Road.

In addition to the hyperendemic areas, there are more extensive areas of milder endemicity. For example, in the Western Hemisphere malaria is endemic throughout the greater part of northern Mexico except in the highlands; in the United States from central Texas through eastern Oklahoma and Missouri to the southern part of the Great Lakes area and even into Central New York state; throughout the southeastern states, and in a few places on the Pacific Coast. However, the only areas in the United States where today there is any degree of high endemicity are the following: (1) a triangular area from Charleston, South Carolina, extending in a southwesterly direction down to central Florida, (2) the so-called "delta area" of the Mississippi from Cairo, Illinois, down to Natchez, Mississippi, and (3) a small area at the mouth of the Rio Grande. But malarious areas in the United States, both in size and intensity of the infection, compare very favorably with the much denser malarious areas to which I have already referred.

EPIDEMIOLOGY OF MALARIA

In these malarious areas, whether they are mildly endemic or hyperendemic, there is always the possibility of epidemics. These may break out in a native population, if certain physiographic or climatic factors are changed. But more likely they occur when a new population is exposed to malaria, and such is the case with our own men who are in the fighting fronts in the tropical theaters of military operations. They are essentially all non-immune and they are continuously exposed to the bites of infected mosquitoes which contract malaria from native populations saturated with the infection.

Let us next consider the way in which infection is acquired. Long delicate thread-like objects, the sporozoites, are the stage found in the salivary glands of the infected mosquitoes during the infective stage. When madam mosquito prepares to take a blood meal, introducing her proboscis into the skin, she injects a few droplets of saliva containng the parasites *(sporozoite stage)*.

INCUBATION PERIOD

According to the idea of Schuadinn, proposed in 1905, the sporozoites, on introduction into the peripheral blood vessels, immediately enter red blood cells, round up and become the typical signetring form with a rim of cytoplasm, a nuclear body and a large central vacuole. This hypothesis has been handed down in medical textbooks and in medical schools for thirty odd years, but it is an incorrect conception. All of our evidence points in an entirely different direction, namely, that for the first four or five days after introduction into the human body these parasites occur outside red blood cells. We refer to this early stage as the *exoerythrocytic stage.*

What evidence do we have that such a stage or such a focus of the infection exists in the human body? First of all, if you were to try to recover those delicate, spindle-shaped sporozoites two or three minutes after their introduction by a mosquito into the human body, even though you used

as much as five hundred cc. of blood, you would usually not be able to find a single parasite. They would have completely disappeared from the peripheral circulation. Then, where have they gone? Our evidence is not entirely direct insofar as human infection is concerned, but here, just as Ronald Ross did, malaria in birds has been used to elucidate the problem. Probably the same thing occurs in man as in the bird, namely, that almost instantaneously after these parasites have been introduced into the skin, they disappear from peripheral circulation. If you take a bird so inoculated and ten minutes later sacrifice it, take the pulp from spleen, liver, lungs, lymph-nodes or brain, and use this as an inoculation for other birds, the recipient birds will become infected, indicating that the parasites had actually become located in the visceral centers almost immediately after they had been introduced into the susceptible host.

Furthermore, we know from the recent work that has been done on bird malaria that these parasites are found in the reticuloendothelial system and it seems quite probable that immediately on being introduced into the body from the mosquito, they have been engulfed by wandering macrophages, and have been carried to the centers of reticuloendothelial activity. Instead of being killed in these cells they have developed and multiplied during the early stages of the infection. They multiply by segmentation, technically known as *schizogony.* Apparently, in the case of tertian malaria, there are usually at least two such periods of asexual multiplication covering approximately four days, during which the parasites are exclusively in the reticuloendothelial system. Shortly thereafter, an exodus of some of the parasites occurs and some of them are able to invade the cells lining the smaller blood vessels, particularly of the viscera; then some of the asexual daughter organisms *(merozoites)* invade the visceral red blood cells and establish the infection for the first time in red blood cells approximately four or five days after the individual has been inoculated.

The earliest stage of the parasite seen in red blood cells is the signet-ring stage, which grows at the expense of the hemoglobin, utilizing the "globin" portion and depositing the undigestible "hem" in its own body. Then the plasmodium segments, setting free the asexual daughter cells, or merozoites, into the blood plasma, to infect other red blood cells and carry on the infection.

Thus, the infection is built up by this asexual segmentation process, schizogony, until approximately fourteen days after inoculation enough red blood cells have been infected so that with their bursting, there is a considerable amount of toxin set free into the blood plasma. This produces the episode which we know as chills and fever. Repetitions of these attacks of chills and fever recur for several such cycles. Usually, if the individual has tertian malaria and is untreated, these cycles will recur every forty-eight hours for approximately three months and then there will be a latent period of about three months, followed by a relpase.

In the meantime, during that three months' period free of clinical evidence of infection, you will ordinarily not find any parasites in the peripheral blood, but some are residing in the original focus in the reticuloendothelial system which we like to think of as a residuum of infection responsible for the relapse, wherever and whenever it occurs.

Moreover, after a while, sometimes even as early as the first chills and fever, we find that some of the parasites have entered red blood cells and have developed into another stage of the infection, the mother sex cell or *gametocyte.* This stage is incapable of multiplication within the human body. It develops at the expense of the red blood cell, but unless it is picked up by the appropriate mosquito, it soon dies. This is the stage for carrying on the infection outside the human body.

Where do the gametocytes come from? The chances are very great that these mother sex cells come from the residuum of infection in the reticuloendothelial centers. In order to get the infection the mosquito must pick up blood from human beings that have the mother sex cells in the proper stage of ripeness. Necessarily there must be one female mother sex cell and one male mother sex cell in each sampling of blood which the mosquito obtains in her blood meal.

MALARIA IN THE MOSQUITO

Once the gametocytes are taken up in a blood meal by the mosquito, they are passed down through the mosquito's pharynx and esophagus into the large stomach portion of the midgut, where maturation occurs. The female gametocytes become mature eggs and the male gametocytes each produces a few spermatoza-like organisms. One of the male cells fertilizes one of the female cells to form the fertilized egg and this fertilized egg now actively migrates between the cells of the stomach wall and comes to lie as a little spherical or ovoidal cyst (oocyst) on the outer side of the stomach wall, bathed in the liquid nourishment of the blood cavity. The cyst increases in size and becomes a sporocyst, internally developing large numbers of sporozoites. When this sporocyst has been completely ripe, the sporozoites are set free and migrate all through the blood cavity of the mosquito but finally accumulate in the salivary glands, so that when she next makes her blood meal, she will be ready to introduce the infective stage into man in a few droplets of saliva.

Shall we consider for a moment the infection

in the mosquito before coming back to malaria in man? In the mosquito, under ideal conditions, tertian malaria parasites require approximately ten to fourteen days under optimum conditions to mature and produce the sporozoites which constitute the infective stage for man. For the tertian parasite these conditions are at about an average temperature of 77° F. (25° C.). In the quartan infection the period is longer but the incubation temperature is lower, namely about 71° F. (22° C.). In the estivoautumnal infection the optimum temperature is considerably higher, namely, an average of about 86° F. (30° C.). At this temperature the estivoautumnal parasite will mature in approximately eight or nine days. This biologic information has a very practical application, because the data fit in very definitely with our knowledge of the distribution of these infections over the face of the globe, particularly in the case of tertian and falciparum infections. The tertian parasite will stand warm temperatures. It will also thrive in cooler climates, so that throughout wide bands of temperate zones as well as in the tropics tertian infection thrives.

In Portland falciparum infection is not likely to become established, because this requires too high a mean temperature, but Portland's temperature is compatible with tertian infection. The same is true for New York State and was in years past in the Connecticut River Valley and in Southern Ontario. The same holds true even today for Northern Europe, as in Northern Germany, Denmark, the southern part of Scandinavia and extending through Russia into Siberia, where in the summertime there are rather extensive epidemics of tertian malaria. Similarly, on the other side of the equator in the temperate zone, tertian infection is quite common. But throughout the broad tropical belt, although there are extensive infections of tertian malaria, the predominate form, particularly from a clinical point of view, is the estivoautumnal parasite, because it is especially adapted to this high temperature.

Moisture, of course, is another very important factor. Without moisture, the mosquito would dry up and there would be no malaria because it is requisite for the completion of the life cycle of the parasite. Likewise, mosquitoes have many natural enemies and these keep them down. Then, among other climatic factors, deluging rains will wash out breeding places and drying winds will dry up the pools of water to cause the death of the mosquito larvae.

In spite of these facts, Anopheles mosquitoes are abundant throughout most areas in the tropics except in the desert and it is necessary to remember that there are frequently little pools in oases.

Under controlled conditions in the laboratory, there are many mosquitoes which are susceptible to infection with the parasites of human malaria, but some prefer animal to human blood. Therefore, if there are any animals around, human beings are more or less protected. But hyperendemic malaria develops in those areas where the mosquitoes are practically one hundred per cent feeders on human beings and where the native population is heavily infected with malaria.

Let us examine a typical female Anopheles mosquito. You will note she is distinguished from the other mosquitoes by the fact that typcially her body lies in a straight line all the way from the tip of her proboscis to her abdomen; likewise, the posterior pair of legs dangle in the air and are not in contact with the surface on which the mosquito lies. During the larval stage, this mosquito breeds and feeds with its body just under the surface of the water. It has no projecting breathing tube as Culex or Aedes has. It must lie like this in order to get air from above the water level and it feeds in this surface-film, turning its head around one hundred eighty degrees in order that the oral side of its head may be in a position to feed in the surface-film.

PATHOGENESIS OF MALARIA

Let us next consider the effects produced in man when these malaria parasites have increased in numbers sufficiently to produce chills and fevers, the first clinical evidence of the infection. Obviously, there has been rather slowly built up during a previous period of several days an amount of toxic material which has been discharged into the blood stream as the parasites increased in numbers and broke out of the red blood cells. Furthermore, the broken down by-products of the erythrocytes which have been destroyed, as well as considerable accumulations of hematin, are passing through the blood stream.

If hourly temperatures of exposed individuals are taken, beginning about the sixth or seventh day or certainly on the eighth day after exposure, you would find a slight elevation of temperature which would continue for several days until the first paroxysm of chills and fever occurs. Thus, the first chills and fever are actually not the first evidence that we would have. If we knew that the individual had been exposed a certain number of days previously, we could actually know that the patient was in a prodromal stage of illness. The chill is mere by an apparent thing, because if we took rectal temperatures at the time of the chill, we would find that there was an elevation of temperature. But due to the contraction of peripheral blood vessels, temporarily there is a chilly sensation. Then, when dilation of these vessels occurs, the individual feels as if he were burning up. After a few hours, defervescence comes on with excessive sweating.

Except for feeling exhausted the patient will now be in a rather comfortable state. But within thirty-six to forty hours in tertian malaria there is a repetition of the same paroxysm, and this

will be repeated more or less regularly every forty-eight hours. The condition is similar in quartan malaria, except that the cycle is seventy-two hours and the number of asexual daughter units produced each seventy-two hours is fewer than in each forty-eight hour period in the tertian infection. As a result, quartan infection builds up much more slowly.

One thing that we must reckon with in estivoautumnal malaria is that the peripheal blood picture is no true index of what is going on in the body. This is the reason why estivoautumnal malaria is such a dangerous, insidious infection. We do not find all of the stages in the peripheral blood or even an average sample of them. The early ring stages are the only asexual form seen in the blood film of the average patient. There are also the so-called "crescents," the ripe gametocytes of estivoautumnal malaria. We find neither the more mature trophozoites, schizonts nor unripe gametocytes. Where are the intermediate stages which are absent from the peripheral circulation? They are typically in visceral blood. For example, if we were to take blood from the liver, spleen or bone marrow, or the placenta following delivery of a child of an infected mother, we would find these parasites in large numbers. As a matter of fact, if in estivoautumnal malaria we observe all of the segmenting stages in the peripheral blood, the prognosis is usually poor.

If malaria parasites kept on multiplying as rapidly for the next five to ten cycles after the first paroxysm as they had preceding that paroxysm, they would occur in numbers absolutely incompatible with the number of red blood cells normally present in the body or which could be produced by stimulation of the hematopoietic organs. This brings us to another very interesting point, namely, that these parasites in the average individual stimulate an immune reaction, which is expressed first by increased activity of the macrophages and then an increased production of macrophages. These phagocytes engulf and destroy the little merozoites very rapidly as they escape from the infected red blood cells. This is the way in which the system tends to produce a balance between itself and the invaders. As an example, an individual, who normally has five million red blood cells per cubic millimeter of blood, would suffer from an anemia because he now had only two and a half million cells. However, an equilibrium would possibly be established at that level by the killing off of many of the merozoites just as soon as they were produced. Furthermore, it is probably this immune reaction on the part of the host which stimulates the production of the mother sex cells by the parasites.

What are the underlying disease-producing causes in malaria? First of all, the toxins, which each time there is a discharge of merozoites every are set free in the circulation of blood plasma forty-eight hours or seventy-two hours, are sufficient to produce the chills and fever. Next, with the destruction of red blood cells there is anemia, which later on may become the most conspicuous aspect of the infection. In the third place, and this is particularly true of the estivoautumnal parasite, these parasites tend to accumulate in large numbers in the blood sinuses of the spleen, the liver, the lymph-nodes and the bone marrow, and in the capillaries of the lungs, the kidneys, the adrenals and particularly the brain. Furthermore, estivoautumnal parasites tend to agglomerate, thus producing little emboli in the smaller blood vessels. This explains why individuals with this infection, out of an almost clear sky, will develop a coma which has to be handled very rapidly, else the individual will not survive.

PATHOLOGY AND SYMPTOMATOLOGY

The spleen in malaria becomes enlarged; at first it may be soft but sooner or later it becomes hardened and sometimes fibrous, and is grayish purple to melanotic in color. Its sinuses and capillaries are crowded with the parasites. Likewise, the liver becomes enlarged and pigmented. The bone marrow becomes engorged, red and hyperplastic. The kidneys frequently manifest hemorrhage, at times thrombi, with a subacute glomerular nephritis. The adrenals develop an arteriolar occlusion. The brain becomes congested, particularly in the estivoautumnal infection, with numerous thrombi wherever there are agglomerations of these little parasites. At times there is a fatty degeneration of the heart.

The toxic by-products thrown out into the blood stream account for the malaise, the chills and the fever. The anemia, like that of any other etiology, has its own sequelae. The occlusions are responsible for the enlargements of the visceral organs and for the albuminuria. In patients with blocked kidneys, there may be hemoglobinuria or the more serious complication of blackwater fever in estivoautumnal malaria. There may even be anuria. There is likely to be a reduced adrenal secretion, with evidence of hypertension. The occlusions in the brain are most commonly productive of coma.

SPECIFIC DIAGNOSIS OF MALARIA

How can malaria best be diagnosed? If the parasites are abundant in the peripheral blood, a well-prepared thin blood film, stained with Wright's or Giemsa's stain, will provide excellent material for diagnosis. But if the infection is in a more chronic state, thin blood films are likely to be time-consuming and frequently misleading in providing only a negative diagnosis. It is now almost the universal practice in the tropics to utilize thick blood films that are sufficiently thick so there are several layers of red blood cells on top of one another and about the area of a nickel.

These films must be properly prepared on an absolutely clean slide and allowed to dry properly, then dehemoglobinized and stained preferably with Giemsa's stain. Diagnosis of such films requires experience because the plasmodia do not look as they do in thin blood films. However, the thick film is the method of choice in making routine survey examinations for malaria and is utilized in large hospital practice in the tropics.

Sometimes placental blood will provide evidence which peripheral blood does not show. Occasionally, it may even be desirable to do a biopsy of sternal bone marrow. In a few cases in New Orleans, where we have been unable to obtain diagnoses from thin or thick blood films, we have found the parasite in the sternal bone marrow.

There is another partially satisfactory method of determining infection in a population group in malarious areas, namely the so-called spleen rate as contrasted with the parasite rate which is determined by actually finding the parasites in the blood. The spleen rate is derived from determining the number of palpable spleens in a particular community. The examiner does not usually examine the spleens of everybody in the group because those of adults are sometimes very difficult to palpate. Therefore, children of preschool and early school age are used to determine how endemic or hyperendemic malaria is in a particular area. It has even been stated by an eminent malariologist that the physician who does this spleen index work should get used to doing it while the patient is standing up. The examiner comes up behind the patient unawares and simply feels the spleen while the child's attention is being diverted to something else, because usually time does not permit, and likewise natives will not always submit to lying down and having their spleens palpated. However, the spleen rate has its shortcomings, because there are many other diseases which produce a splenomegaly and these must be considered in making up an appraisal of the value of a spleen rate as an index of malaria in any particular community.

The parasite rate is not subject to any such criticism. The proper recognition of the parasites and the differentiation of the different species of malaria parasites, and ideally even their stages, constitute the method of choice wherever such work is carried out. In our military forces the parasite rate is the one which is being utilized on all occasions. Wherever it is possible, the same method is being employed to determine the amount and types of malaria in native populations.

PROGNOSIS

Generally speaking we may say that in tertian malaria the prognosis is good, particularly if there is adequate but sane antimalaria treatment. There is one simple way in which we can evaluate the effect of treatment. If there are continued large numbers of the asexual stages, i.e., the rings and schizonts, in blood films, the individual is not producing adequate immune reactions to the infection and will continue to have clinical malaria with recurrence of chills and fever. On the other hand, if there are few or none of the asexual stages and many of the gametocytes, then, clinically speaking, the prognosis is good. In estivoautumnal infections, there is always the likelihood or possibility of occlusion of small blood vessels in various foci, thus rendering prognosis of this disease always a hazard as long as the infection persists.

TREATMENT

May we next take up the question of treatment. First of all, it must be confessed that there is no known drug which is completely satisfactory in eliminating malaria parasites from the human body. In spite of the value of quinine, of atabrine and of plasmochin, no one or combination of these drugs can be guaranteed to eliminate malaria parasites from the human body. If the individual cannot muster an immune reaction in his own body, the chances of eliminating these parasites are very scant indeed. What quinine or atabrine does is to clean the parasites out of the peripheral and visceral blood, but there is no guarantee that either of these drugs will destroy the parasites in the reticuloendothelial centers.

Plasmochin is too toxic for use in full therapeutic doses against the asexual stages of the parasites, but it is very effective in sterilizing or actually killing the gametocytes. It is prophylactic in that the individual patient is unable to provide infection for the mosquito. Plasmochin also tends to reduce the relapse rate. If this is true and if relapse stems from the residuum in the reticuloendothelial centers then plasmochin apparently does reach the parasites to a certain extent in the centers from which new streams of infection flow.

However, there is no single drug which will prevent an individual once inoculated from acquiring the infection. In that sense, we have no true prophlyactic. In other words, we can take quinine or atabrine for an indefinite period of time and if we then went to some hyperendemic area, we would still be susceptible to infection. There is nothing that we know of today which will kill the sporozoites as they enter the skin and nothing that will prevent them from getting into exoerythrocytic centers and developing there.

What we do recognize today is the following: that in quinine and atabrine we have moderately good drugs for taking care of clincal malaria and frequently, with aid of the patient's own immune mechanism, for cleaning out the infection, if the patient is treated early enough and intensively

enough. This is what is referred to as **curative treatment.**

I have mentioned that there is practically nothing in the way of preventive treatment. On the other hand, we have fairly satisfactory **suppressive treatment**, in which we give either quinine or atabrine in reduced doses over the entire period of time during which an individual is exposed in endemic or hyperendemic areas.

If a patent comes to a physician with clinical malaria he should be given the full therapeutic course (i.e., **curative treatment**). In the case of quinine, quinine sulphate is administered by mouth in the amount of ten grains three times a day, usually with meals, for a period of four to five days; followed by ten grains a day at night for a period of four to five weeks or more. This is the standard quinine treatment for malaria. Usually in early cases, if the individual is able to develop an immune reaction, one or two courses of treatment will probably clean out the infection, but there is no absolute guarantee.

The full therapeutic course of atabrine consists in the oral administration of one one-tenth-gram tablet three times a day with meals for five to seven days, making a total of fifteen to twenty-one 0.1 gm. tablets. It has been found, on the basis of extensive experience in the tropics with large numbers of individuals employed in plantations, that they will readily take the atabrine for this short period of time, because it is practically tasteless and they get practically no after effect from it.

Three to five days after the intensive 30-grains-per-day quinine treatment plasmochin should be given in the amount of 0.01 gm. daily for four or five days to sterilize the gametocytes and possibly to reduce the relapse rate. Plasmochin should also be given with atabrine, but never until after atabrine treatment has been discontinued because it and plasmochin are incompartible. Therefore one should wait for at least two or three days after the full five-to seven-day course of atabrine treatment, and then give the plasmochin.

Next, let us consider **suppressive treatment.** Here we attempt to start the treatment before the individual is exposed. The amount of time which is now found to be desirable is two weeks before the individual enters a hyperendemic area. The suppressive treatment with quinine is ten grains daily, taken usually at night. However, today we have a very small amount of quinine on hand and the chances are that very little of it will be available in the immediate future compared with the amount of suppressive treatment that our troops will require. Thus, suppressive treatment with atabrine is advised. This drug is probably as good as quinine and is available now in excess of all estimated needs. The suppressive treatment consists of four to six one-tenth gram tablets a week. It can be administered in the amount of one-tenth of a gram daily, six days a week, omittting Sunday.

Atabrine has advantages over quinine for air personnel because it does not change depth perception or color values and produces no toxic reactions in fliers even above a thirty-thousand-foot ceiling. On the other hand quinine is essentially contraindicated for fliers because of tinnitus and loss of equilibrium which develop.

Up to the present time, insofar as I know, none of the sulfonamides has proved to be of real specific value in human malaria.

Frequently it is necessary to transfer a chronic malaria case from the tropics to a cooler climate before his immunity mechanism is able to develop to a point where he can become free of the infection.

PRESENT STATUS OF MALARIA

Now, shall we very briefly take up the question of the present status of malaria? Usually in the past we have discovered that there were waves of malaria that occur every five or seven years. One appeared in the Southern United States about 1924 and another about 1929-1930. Then came a drop a year or two later and following that we had the economic depression, with a tremendous increase in malaria. Thereafter the incident gradually decreased to an unusually low level but we expected another increase about 1938 or 1939. This did not develop, probably due to efforts made on a scale not previously attempted to drain malarious areas, to use oil and Paris Green to kill the mosquito larvae, to give adequate nourishment to individuals in the areas, to screen the houses, and, wherever individuals were infected, to give them either adequate quinine or atabrine treatment. Up to the present time (August, 1943) this expected increase has not occurred. Only in case malaria is brought into the country in large number of patients and is allowed to get into the mosquito population, is there a great likelihood that malaria will be, in the immediate future, a serious problem in our midst.

Thus, we find that malaria is world-wide throughout the tropics and extends into temperate zones. There will be many people coming to the United States in the near future, our returning soldiers, sailors and marines and others who have been out on the fighting front, and later on individuals who have gone into tropical areas, not on military missions but on business or pleasure. Many of these repatriated persons will have picked up malaria and brought it to the United States. Thus, we cannot ignore malaria, even though our mortality and morbidity records at the present time are more satisfactory than they have been at any time in our past experience.

Meeting Today's Health Problems

EARL E. KLEINSCHMIDT, M.D.

TODAY, as perhaps never before in our entire history as a nation, the American people are keenly aware of the fact that health is essential to the successful prosecution of the war in which we are presently engaged. No nation can long survive the hardships of modern warfare which does not heed the axiom that it is the strong who survive. But physical strength in itself cannot assure us of victory today, unless it is shielded by the protective armamentarium of modern scientific medicine. Indeed, upon our continued ability to meet and solve the health problems confronting both the military and civilian populations today may well determine the future course of this war.

History is replete with dramatic examples of the influence of disease in shaping the course of battles, and in determining the rise and fall of nations. From the days of ancient Greece and Rome to the present time epidemics have played a vital role in determining the outcome of military operations. The world has never seen, and probably never will see, the military genius who can ignore the factor of disease. Hannibal, it will be recalled, was cheated of his conquests by illness in his army. Napoleon, in his retreat from Moscow, felt the sting of disease and the crippling effects of physical deterioration of his men. In World War I malaria immobilized large numbers of British, French, and German troops in Macedonia. Eighty per cent of 120,000 French troops were hospitalized; and among the British with a strength of 124,000 men, there were 162,000 admissions between 1916 and 1918. Over 10,000,000 cases of typhus fever occurred in Europe alone with an estimate of 5,000,000 deaths.

Today's global warfare greatly increases the possibility of such recurrences should the conflict continue indefinitely in those areas of the world where epidemic diseases are commonplace.

GLOBAL WARFARE INTENSIFIES SPREAD OF DISEASE

Modern war is no respecter of nations or their boundaries—either man-made or natural. The same can be said today of disease. Malaria, dysentery, plague, typhus, and yellow fever, which only yesterday were regarded as medical curiosities of academic interest only in the United States by the average physician, may today come to this country in planes, on boats, and in the blood streams of returning soldiers. Air transportation has leveled all geographical boundaries; it has broken down all barriers of time, space, and natural boundaries, which have hitherto served to confine epidemic diseases to certain segments of the Earth's surface. Thus, infected disease vectors such as, for example, the mosquito, fly, gnat, and other insects may now become stowaways on planes in the Congo and travel unharmed to Brazil or Florida and there attack humans previously not exposed to such perils. The global nature of the present conflict, with the movement of troops and civilians as well these days to the far corners of the earth, will undoubtedly result in bringing tropical diseases to the forefront as a public health problem of serious proportions in the United States. The war against these diseases now becomes an international problem to be solved by science—medicine and education—and the safe and right use of available health facilities wherever we happen to be.

The Author

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HEALTH ACHIEVEMENTS SPECTACULAR

But ominous as these possibilities may appear at the moment, we should take especial pride in the fact that the Medical Corps of the armed forces of the United States has won a signal victory against dangerous epidemic diseases abroad. It has been almost 100 per cent successful thus far in combatting dangerous epidemic diseases against which it has been able to use preventive innoculations. Thus every member of the armed forces on induction today is immediately protected through immunization or vaccination against smallpox, typhoid fever, and tetanus. Further protection against cholera, yellow fever, typhus, and plague are given those being sent into areas where these diseases are endemic. (I wonder what our good friends the anti-vaccinationists will have to say to this!)

Thus, in a report[1] covering the entire period of the war up to July of this year, there were no cases of cholera, tetanus, or smallpox reported, and only 12 cases of typhoid fever from the China, Burma, India theater of operations. In the middle east and North Africa there were four

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mild cases of typhus fever, but no deaths reported. This is a magnificent achievement by the medical corps, and especially so, when it is appreciated that several severe outbreaks of typhus fever were prevalent in both theaters of war among the native population. American troops have remained singularly free of the scourges which usually serve to handicap armies in foreign lands despite prevailing insanitary conditions and appalling conditions of ill-health and poor personal hygiene among the natives. This achievement stands as mute testimony to the effectiveness of modern preventive medicine and public health in enabling an army to survive and carry on even in the most unfavorable terrain of the world.

ETERNAL VIGILANCE NEEDED ON HOME FRONT

Were our public health programs on the home front to function as effectively against much less dangerous disease enemies among the civilian population, we would have real cause for exultation!

As a nation we still permit smallpox, diphtheria, whooping cough, tetanus, typhoid, tuberculosis, rheumatic fever, and dozens of other preventable diseases to take their annual toll. To be sure, we have made great progress in bringing them under better control in recent years, but let no one think for a single moment, that these killers of mankind are incapable of returning to the scene of their previous triumphs should we relax temporarily in our efforts to keep them in check.

Tuberculosis, syphilis, cancer, heart disease, and other killers of mankind show no signs whatsoever of adopting a forty-hour week; instead, there is every reason to believe that unless society continues to press its fight against them with undiminished vigor we may shortly see an upsurge in their incidence as we did during and following World War I.

The war against disease must, therefore, be waged with the same vigor and intensity as the fight against our axis enemies. Both are enemies of civilization—one quite as dangerous to our immediate existence as the other. A healthy civilian population is at the moment a prime requisite as a source of a healthy and vigorous military organization. Obviously, the stamina and health possessed by civilians on the home front are essential to the building of a strong and successful army and navy. Second only to the prompt organization of an efficient system of military preventive medicine comes the machinery for the preservation and improvement of the health of the civilian population. This is basic to success in this war.

Never does public health work become more important than in preparation for war and in time of national peril. Good public health work over the past quarter century is today paying dividends by furnishing a continuing supply of able-bodied men to the armed forces; it is also providing a healthy and efficient army of industrial and agricultural workers to produce materials of war; and lastly it stands as a guardian over the lives and happiness of the mothers and children in every community wherever the protecting arm of the family physician has been temporarily removed.

IMPORTANCE OF PUBLIC HEALTH WORK RECOGNIZED

As a consequence of public health work over the past half century—superficial though it may appear at times—our standards of health today are the highest ever attained. Our death rates—crude, maternal, and infant—have reached an unbelievable low in most sections of the country. The birth rate for the country at large has risen from 18.7 per thousand in 1941 to 23.2 in 1943. Interestingly enough, the national crop of babies has reached unprecedented numbers. Close to 2,000,000 more babies will have been born in the United States since 1933 than would have been born had the 1933 birth rate prevailed.

With the exception of outbreaks of meningitis and poliomyelitis there have been no other widespread epidemics of serious proportions this year, although there have been minor flare-ups of smallpox, typhoid, dysentery, and food poisoning in various sections of the country—none of which, fortunately, got out of control.

The strenuous efforts being made by health departments to control the traditional upturn in venereal diseases and tuberculosis deaths have met with decided success thus far. Neither disease has shown a perceptible increase in available statistics compiled by the Public Health Service. Two weeks ago, at a meeting of the American Public Health Association in New York City, General Simmons, Chief of the Preventive Medicine Division of the United States Army, said: "It is gratifying to report that in no month of the current conflict has the admission rate for venereal diseases been as high as the lowest monthly rate of the last war."[2]

The same favorable picture is to be noted in the civilian population. Fortunately, in this war, both army and civilian health authorities have not had to be prevailed upon to maintain strict venereal disease control measures in all military and extra-cantonment areas. There has been the closest kind of liaison relationship between the representatives of the two organizations. It is extremely fortunate, by virtue of federal assistance granted under the provisions of the Venereal Disease Control Act of 1937, that most large communities were able to build strong and effective organizations to combat this menace in pre-war times.

Largely because of improved economic con-

ditions in recent years, the American people have, I believe, availed themselves to a greater extent of good medical care than ever before. Inexpensive systems of health insurance and prepayment plans have enabled many persons to benefit from medical services who might otherwise have gone without such needed attention.

DANGERS OF WAR-TIME EVENTUALITIES

But impressive as these facts may appear at the moment, the marvelous triumphs of preventive medicine of yesterday are today in jeopardy because of war-time eventualities. The present shortage of physicians for civilian practice will continue to increase until the requirements of the armed forces are fully met. Many of our smaller communities are fast approaching a point of danger with regard to sufficient medical personnel to care for their medical and health needs. No industrial or military community, for example, should have less than a ratio of one physician to 3,000 population if its citizens are to have even a fair standard of medical care. Health department staffs are likewise being rapidly depleted in order to supply needed personnel for the armed services. The shortage of dentists, nurses, and other health workers will also become more acute before many months have passed.

Added to these problems are those health hazards resulting from the influx of defense workers and their families in many cities with consequent over-crowding and insanitary housing conditions. The dangers of tuberculosis, syphilis, meningitis, rheumatic fever and other "crowd" diseases in such circumstances is not generally appreciated. Rheumatic fever, for example, exacts a far greater toll among children under these circumstances than any other disease of childhood. Bear in mind, if you will, the acknowledged fact that this disease alone is responsible for 80 per cent of the deaths from heart disease below the age of forty.

All these problems add up to precisely one thing: We health workers—and I most certainly include all members of the teaching profession—need to guide and teach the American people to enable them to compensate for this shortage of health-medical personnel **by placing greater emphasis than ever before on hygienic measures which aim at the prevention of disease and the promotion of health.** This is a fitting challenge to our ingenuity and skill as health workers.

WHAT CAN WE DO?

Speaking with reference to the attitude of the public toward the national physical fitness program, a leading health authority has recently said that, "Today is the most teachable moment in history."[3] The majority of the people, I find, are anxious these days to keep themselves healthy and fit to meet their responsibilities as effective contributors to the war effort. The impelling motive for sustained health—patriotism, winning the war, sufficient income for self-support, increased usefulness and productivity—are present now as never before. We health workers should capitalize on this unique opportunity and make sure that the people are given every opportunity to learn **what they can do to maintain their health and thus help win the war!**

From the standpoint of the schools, teachers should continue to extend their programs of health instruction and health guidance—difficult though this may prove to be. This is said in full recognition of the fact that you as teachers are already being called upon in large numbers to perform many other functions in connection with the war effort in addition to your regular classroom activities. But it is more necesssary than ever, that you teach the whole child. The teaching profession can ill afford to ignore the health component in today's classroom.

An over-taxed medical profession is struggling under great odds these days to meet the increased public demand for its services. Even under existing circumstances, physicians are of necessity dispensing with many of their preventive services ordinarily rendered their clientele in peace-time, and engage, instead, almost exclusively in the diagnosis and treatment of disease. A shortage of manpower has likewise served to curtail the programs of both official and unofficial health agencies leaving but a skeleton staff in many instances to carry on the work.

In the face of these circumstances, school people and public health workers as well can not escape the conclusion that greater emphasis must be placed on the teaching of hygiene—personal and community—in our schools and the community at large these days to effectively reduce the necessity for medical treatment of preventable disorders in the community. Health education in its broadest meaning is in essence the most potent weapon at our disposal today for the prevention and control of disease. It should be employed to the utmost in helping people adjust themselves to existing conditions.

CRISES BEGET SELF-APPRAISAL

As some leading health workers have pointed out, the present crisis may prove to be a blessing in disguise insofar as it clarifies our thinking with respect to what is essential in a community health program. Each of the major wars in which this country has been engaged, beginning with the Civil War, has brought in its wake certain new concepts as to what was needed to better conserve human health.

Following the Civil War came the birth of the movement for the establishment of state departments of public health; as a result of the Spanish-American War there developed an appreciation

for improved environmental sanitation and more scientific measures for the control of typhoid fever and related filth-borne diseases; "Teddy" Roosevelt's zeal for physical fitness of his rough riders, it will be recalled, gave rise to the camping movement, sleeping out-of-doors; and perhaps most noteworthy, the movement for the prevention and control of tuberculosis, which at that time led all other diseases as a cause of death in the United States; his interest in child health led to calling the first White House Conference on Child Health in 1908. At the conclusion of World War I interest centered on the deplorable physical condition of the nation's youth with the result that greater attention was focused on school health programs which aimed at improving child health through healthful living, early detection and correction of defects discovered in the course of health inspections, and organized programs of health instruction. In 1922, health was designated as the first objective of education.

We were shocked in 1917 to find that 50 per cent of youth called up for army service were incapacitated because of defective vision, hearing impairments, cardiac dysfunction, hernia, dental caries, tuberculosis, and venereal diseases. Today, we are similarly affected by the findings made by army medical examiners over the past 26 months. But while the percentage of rejections[4] today, 27 per cent, compares more favorably with 52 per cent rejected in 1917-18,[5] it must not be forgotten that medical examinations today are much more exacting owing to improved skill in medical diagnosis than were those in World War I.

If we may consider for a moment what the medical findings from these examinations have been, I think you will agree with me, that the health problems of American youth today are quite similar in most respects to what they were in 1917-18. Statistics[6] reveal that the main reason for rejections today of young men entering the armed services have been as follows:

Condition	Per Cent
Dental defects	20.9
Eye defects	13.7
Cardiovascular diseases	10.6
Hernia	7.1
Venereal Diseases	6.3
Mental and Nervous disease	6.3
Ear defects	4.6
Food defects	4.0
Lung defects, including Tbc.	2.9
All others	24.5
Total	100.0

The first two causes account for more than one-third of all the rejections; the first four causes, more than one-half of the total.

While the press has painted these conditions as "deplorable" and "shocking", may I say to you that neither descriptive term is exactly appropriate. Physical defects like great events cast their shadows before them—long before such a national inventory as the draft examinations.[7] The important things that contributed to the nation's physical unfitness in 1917-18 were demonstrable already among the school children of 1900. The conditions which have resulted in the present rejections were discernible among the school children 15 or 20 years ago, as Ciocco[8] and his associates have recently proven from a comparison made of school health records of draftees with their medical examinations made in the last year. Defects, which were quite evident while these lads were school children, have been allowed to go uncorrected. Each year, undoubtedly, these defects were recorded by some enterprising health-conscious teacher or school health examiner, and a notice sent to the parents, but nothing much ever happened, and this same process goes on even today. The pathway to correction of physical defects of many children is, unfortunately, obstructed by parental complacency and public indifference, which conditions prevent them from receiving the kind of health supervision which they so obviously need.

Someone may say, "Well why don't you public health people do something about this and the many other health problems affecting the American people?" An adequate answer to this complex question would require considerable more time than is at my disposal this evening. It may suffice however, to call attention to the studies on the cost of medical care[9] conducted in 1928, and numerous health surveys made since then by the United States Public Health Service, and other health and medical organizations. As a result of these investigations, we health workers have about arrived at the conclusion, that until the people, themselves, become better acquainted with the economics of health and the present uneven distribution of medical care, that the disparity between available health and medical services and the distribution of these services will continue. Suffice it to say, on the basis of interest manifested by various organized groups in recent years it became increasingly evident, however, that we are fast approaching an era when the problem of human conservation will compare in national significance with the great advances in technical achievement of the past quarter century. As a nation, it must be admitted, we have been guilty in the past of squandering and gross neglect of our human resources much the same as some shiftless farmers treat their machinery.

People still die needlessly today simply because of their inability to pay for, let us say, an X-ray; or in other instances because of carelessness, largely because they were never taught the fundamental facts of life and apprised of the care needed by the human body while students in school. As a consequence many of them shun

the advice and proffered aid of the medical physician, the public health worker, the health educator, and patronize the cultist instead. And, surprising though it may seem, their numbers are not always limited to the less well educated members of a community. I have, as a matter of fact, found health workers in our schools and colleges teaching half-truths and unscientific health practices to children simply because some school administrator adhered to the notion, that anyone can teach health.

PATHS TO HEALTH

Like the roads to Rome which are so much in the news these days, there are many paths available to the seeker of health. Some are old; some new; some are still in the process of construction.

By far the oldest path is the one which leads to that staunch individualist, the family physician. Good citizen that he is, he finds himself today in competition with new and complex organizations which challenge his very existance—but he struggles on, hoping somehow that his right to individual enterprise will enable him to prevail in a rapidly changing social order.

Other paths lead to purveyors of hospital and health insurance; industrial group medical services provide numerous thousands of war workers these days with the essentials of medical care; tax-supported public health and medical organizations seek to guard the health of the people on a federal, state, and community-wide basis; and lastly are the health programs maintained in our schools and colleges to administer to the health needs of the oncoming generations. The enormity of this vast health program baffles the imagination of the average person; yet it behooves every citizen to keep abreast of recent federal legislation affecting this our present system lest we awaken too late to some of the dangers now confronting the American way of providing health service and medical care.

The issue before the American people today is not simply one of "socialization" of health-medical services, as so many people are led to believe, but whether the proportion between the various types of existing health and medical services shall remain the same or be changed.[10] Moreover, it remains to be seen whether or not the federal government is to exercise control over medical education and the professional activities of the medical profession.

Five important trends in the distribution of medical care and health services are apparent to the careful observer today as one surveys the fast changing scene: (1) the development of group medical practice, (2) the growth of tax-supported medical care for needy and other medically-indigent persons, (3) the planned distribution of medical facilities and personnel, (4) the growth of health insurance, and (5) the disappearance of the old concept calling for a separation of preventive and curative medicine in tax-supported health and medical organizations.

The trend of events in medical economics in recent years has been compared to that of a speeding train traveling at great speed to a given destination, which some health authorities believe will eventually become a national plan of health security for every man, woman, and child in the United States.[11]

It is rather significant that within the relatively short period of 15 years, that approximately 20 millions of people have purchased health insurance policies in the United States. Thirteen states have enabling legislation making it possible for private enterprise to establish and carry on such a program. The State of Washington, for example, now has a comprehensive program of health insurance that offers complete medical protection including medical, dental and nursing care.

But this much must be said of health insurance and other prepayment plans as they exist today. Very few of these plans incorporate provisions for preventive health services. The major criticism heard generally concerning health insurance is that it has been too much concerned with the diagnosis and treatment of disease, and too little with the prevention of disease and the promotion of health. In short, it is sickness insurance for the most part rather than health insurance that present policyholders have. Not until specific provision is made for periodic health examinations, early detection and correction of defects, immunization against preventable diseases, and for specific diagnostic tests at regular intervals can it be regarded as health insurance in strict sense of the term.

But much as some of its protagonists extol the virtues of health insurance and other prepayment plans, their value in the last analysis must be judged by the extent of public acceptance and the quality of health-medical services rendered. Medical service of sorts can be obtained by regimenting physicians against their better judgment, but the cooperation of the medical and public health professions will not be obtained unless experiments now in progress demonstrate that the contemplated change in the distribution of medical care is an improvement on the present system.

Right at the present we are greatly concerned with a plan for providing security against the exigencies of sickness and disease for every man, woman, and child in the United States. I refer to Senate Bill 1161, referred to commonly as the Wagner-Murray-Dingell Social Security Plan. It is designated as amending the Social Security Act of 1935. If enacted into law, this bill would require every employer to pay a tax of 6 per cent

up to $3,000.00 on wages paid to individuals. Each employee would pay a tax of 6 per cent deducted from his wages on earned income up to $3,000.00 a year. In this way there would be created a trust fund amounting to roughly twelve billions of dollars with which to finance the benefits of the system.

This plan would be administered by the Surgeon General of the United States Public Health Service in whom all authority and power is vested and a National Advisory Medical and Hospital Council consisting of sixteen members appointed by the Surgeon General.

The bill provides among other things that every insured individual and his dependents shall be entitled to receive general medical, special medical, laboratory and hospitalization benefits. It provides a total coverage of 30 days of hospitalization in any one year. Should ample funds be made available, this may be increased to 90 days per year. Every insured individual will be permitted to select or change physicians in accordance with rules and regulations as may be prescribed by the Surgeon General.

We have here a plan which, like its English counterpart, the Beveridge Plan, is considered primarily with medical treatment and hospitalization. Nothing is found in its contents which would serve to indicate that it had incorporated preventive health services.

Proponents[12] of this legislation argue: (1) that it assures rich and poor alike of good quality medical service; (2) that it spreads the cost of medical care and thus overcomes the common objection that good medical care is too expensive for the low income groups; (3) that it provides for free choice of physicians and does not disturb the physician-patient relationship; (4) that it provides both patient and physician with a degree of security not attainable under the present system; and (5) that it will enable the people to obtain early correction of defects and thus overcome the bottleneck which hitherto has prevented school children and others from having remediable defects corrected.

Opponents[13] of this legislation present the following objections: (1) that it extends federal control of medicine, dentistry, nursing, and medical education to an alarming degree; (2) that it does not take into consideration large segments of the American public not already receiving the benefits of the Social Security Law such as school teachers, farmers, physicians, and representatives of the related health-medical science groups; (3) that it is a political measure designed to regiment Americans and bring under federal direction and control the medical and ancillary health professions; (4) that if enacted into law it would bring about a complete revolution of medical practice in the United States at a time when we can ill afford to further impede the already over-taxed health-medical professions; and (5) that the present system of health service and medical care in the United States has brought about higher standards of health than those found in countries elsewhere having compulsory socialized medicine.

American medicine and public health stands at the crossroads today. It becomes clearly apparent that those persons who are dissatisfied with the existing manner of dispensing health service and medical care are unwilling to wait until the post-war period to bring about so drastic a change in our way of life. They seem bent on bringing this issue before the American public at a time when we might better be devoting our energies to the war effort.

I submit that there are five questions facing all of us as citizens enjoying the benefits of the present system: (1) Is the present plan of providing medical care and health service adequate for our needs—present and future? (2) If not, will further socialization improve the situation? (3) Is this an opportune time in which to bring about a change were the Wagner Bill to become law? (4) Do the American people want to substitue a federal plan of health insurance for plans already organized and backed by private enterprise? (5) Will federal control of medical education be an improvement over the present system?

It behooves every taxpayer to study the contents of this legislation and analyze its contents carefully. The issues at stake are clear; the teaching profession would do well to take a stand in the matter and let its views be known.

SCHOOL HEALTH

Turning next to a consideration of some of the more immediate health problems with which we are presently concerned in our respective schools and communities, it is evident that the most immediate challenge facing us today is the mobilization of school and community resources and services in the interest of training for healthful living and for participation in wartime service and activities at the level where each person serves.[14]

The goals for this program should include: (a) Correction of remediable defects; (b) Prevention and control of communicable diseases; (c) Optimum nutrition for all; (d) Prevention of accidents and skill in first aid; (e) Balanced programs of work, exercise, recreation, and sleep; (f) Attainment of sound mental attitudes; and (g) Meeting health requirements for military, industrial, agricultural and community service.

In this entire health program the classroom teacher can play a leading part.[15] As I intimated previously the present shortage of professional school health workers need not necessarily be regarded as endangering the efforts of the schools

to maintain and improve child health. Instead, it may prove to be a most opportune experiment insofar as it is now possible to put to the acid test the worthiness of a well-coordinated program of health education in the public schools.

It still remains to be seen whether the splendid blueprints for school health programs prepared in recent years by the American Association of School Administrators,[16] the Joint Committee on Health Education of the National Education Association,[17] and the United States Office of Education[18] can be fully utilized and effectively applied by the teacher in solving school health problems confronting her today.

I fully appreciate that all of you are burdened with many extra-curricular activities these days besides your regular teaching duties, but I would appeal to you to help in solving the health problems in your community.

We have a tremendous job to do to prepare American youth for participation in the war effort. Remember, if you will, that your health department and organized medical groups are incapable of doing this job alone. They need your help! As leaders in your community, the present situation should challenge your ingenuity and instil in all of you a desire to prepare youth for the great struggle to maintain our way of life.

The war has already had a profound effect on the home life of many children. According to statistics obtained from the Toledo Department of School Health, there has been a 300 per cent increase in work permits issued thus far in 1943 as contrasted to the number issued during 1942. Particularly significant is the marked increase in the number of work permits issued to 15 year old boys and girls. This is undoubtedly characteristic of what is happening all over the country today.

There are factors for good and evil in this situation. For one thing it is certain that many of these youngsters are making important contributions to the war effort. But what about the effect of this added burden on the health of these youngsters?

While it is difficult to evaluate fairly the effects of this premature thrusting of youth into industry, it can be said, that high wages paid to youth unaccustomed to spending money, has unquestionably resulted in much youthful folly and dissipation. In highly industrialized areas, such as Toledo, where many youngsters are working long hours in addition to their school work, many are not obtaining well-balanced nourishing meals. Many a home today is just a place to grab a doughnut and hang one's hat for many adolescent children. Juvenile delinquency has undergone a marked increase all over the country. If these conditions continue more or less uncontrolled, we shall undoubtedly have an increase as well in tuberculosis in this age group.

It has been repeatedly brought to my attention of late that physical defects in children go uncorrected these days simply because parents have no time to take care of these problems. Since we, of necessity, may oftentimes have to wait several weeks for an appointment with a physician or dentist, this becomes a serious problem.

Lack of parental control of amusements for children, coupled with increased work for young people, often results in chronic fatigue—a "malady" which, by the way, holds quite as dangerous potentialities these days for our young people as an epidemic disease or malnutrition. These are dangerous gaps in the health ramparts we watch today.

OVER-EMPHASIS ON ACTIVITY

So much emphasis is being placed on becoming physically fit these days in our schools and colleges in terms of motor abilities such as the ability to run, jump, climb, and swim, that it is oftentimes overlooked that good health is basic to the development of all these abilities. The development of strength, for example, is quite as dependent on normal growth and development and proper food consumption, as it is on physical activities which bring the large muscles into active use.

The development of strength, agility, and endurance in children are desirable goals in themselves for our physical fitness programs, but then it must be remembered that all children are not prepared in a common biological mold; all boys, for example, cannot be considered as potential infantry soldiers or tank specialists. Some will later excel as specialists in motor transport; others will function best as members of ground crews in the air forces, despite their apparent lack of physical stamina and agility in physical training activities while in school.

I fully appreciate that teachers are harried these days by efforts to make a roomful of biologically different children conform to a uniform program of activities in order to satisfy the public, to please educational authorities, and to send youngsters into the world equipped to work and fight. However, as a physician, I would remind you that you cannot hope to do this successfully unless full cognizance be taken of the biological charactertstics of each child. Careful health appraisals are needed to appraise the child's physical development and limitations; also the effect of the program on his biological make-up.

The officers in the Army and the Navy who have come into the schools to advise with respect to the organization of the Victory Corps physical fitness program have told us in no uncertain language what must be done to get high school youth in shape for army service. At the very

top of the list they place—not calisthenics, not sports, not diet? No. At the top of the list of "musts"—believe it or not—they place adequate rest, relaxation, and sleep.

Life today is no longer leisurely with ample time for reflection.

Everyone is under tension, working at top speed, with insufficient time given to the biological needs of the body such as adequate rest, relaxation, a balanced program of activity and rest, good nutrition, and proper elimination. We have become machine-like automatons with too little attention given to keeping the body machine well oiled and protected against the slings and arrows of misfortune.

The day of the simple life is over—at least in our cities. The pre-motor agricultural era, in which, after the day's work, there were only three choices: to read, take a walk, or go to bed, is a thing of the past. And, unless we protect them adequately, the children will be unfortunate victims of our present dilemma.

In order that we meet today's health problems successfully, it behooves us as people interested in preparing youth for the struggle ahead to protect them with every safeguard at our disposal. To this end, I would urge each of you to assume your time-honored privilege of teaching youth the tenets of good health.

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Neuroses

The acute, active, short-lived neuroses, which are transiently or perhaps persistently in evidence, such as anxiety tension, apprehension and panic states, are invariably characterized by some or all of the following observable objective signs:

1. Eyelids widened and seldom blinking, producing a startled mein.
2. Pupils widely dilated and abruptly reactive to light.
3. Brow and upper lip dewy.
4. Lips dry and wet with frequent licking by the tongue.
5. Palms moist and with increased grasp reflex.
6. Hands red, warm (but feeling cold), with active vascular tone.
7. Pulse rapid, with thumping heart (rhythm changes abruptly).
8. Blood pressure (systolic, not diastolic) elevated.
9. Red line effect (skin scratch test) prompt and flaring.
10. Dermographia frequent and marked.
11. Urgency and frequency of bladder and bowel.
12. Penis tucked back timorously.
13. Erectile tissue excitable but quickly collapsible (note nipples).
14. Blood sugar content increased and rapidly fluctuant.
15. Tremor and incoordinate muscular activity frequent.

The more prominent and exaggerated these signs appear the greater is the approach to emotional frenzy.

In chronic, passive, long-lived neuroses, which are persistently manifest, such as neurasthenic, hypochondriac and obsessive ruminative tension states (psychasthenia), there may be modulations suggesting exacerbations of the more acute forms, but these will be characterized in general by some or all of these signs, contrasted with the above:

1. Eyelids heavy and tending to blink especially in sudden light.
2. Pupils tending to be small and sluggish.
3. Brow and upper lips dry and shiny.
4. Lips bluish with rather frequent swallowing and sighing.
5. Hands bluish, cold (feeling clammy), with sluggish vascular tone.
6. Palms wet with lackadaisical grasp.
7. Pulse slow with lazy heart action.
8. Blood pressure low (both systolic and diastolic).
9. White line effect (skin scratch test) prominent, with little flaring.
10. Dermographism infrequent or inconstant.
11. Retention and constipation commonly.
12. Penis dangling despondently.
13. Erectile tissue sluggish and vagrant.
14. Blood sugar content low and exhaustible.
15. Tremor seldom present, and all movement dilatory.

A word of caution is necessary. These presumably antithetic conditions are not to be considered constant and invariable.—Major M. M. Campbell, M.C., A.U.S., Brigham City, Utah, Northwest Med., Vol. 42, No. 12, Dec., 1943.

Treatment of Squint in Childhood

SAM H. PATTERSON, M.D.

THE chief aim in presenting this paper is to impress upon every practitioner the absolute necessity of early treatment in squint or cross eyes.

I will attempt to dispel the idea promulgated at some past date, and still clung to by many, that children cannot be fitted with glasses and nothing can be done about cross eyes until school age. The assuring remark uttered by the physician or some dear relative, "Oh, let it alone. He will outgrow it", should never be made.

The degree of success for a complete cure of squint depends largely upon the age at which treatment is begun. By complete cure I mean that not only shall the deformity be corrected, but binocular vision shall be restored and the visual acuity of the two eyes be equal. These requirements are difficult to obtain even when treatment is instituted at the very beginning of the squint, and postponed until after the age of six they are impossible. All you can hope for then is cosmetic results.

The cosmetic benefits however in this condition are not to be minimized.

A squint is a deviation from parallelism of eyes which is not overcome by involuntary effort. This differentiates it from phorias or latent squint, which is overcome by involuntary effort.

The chief or only symptom in children is the apparent disfigurement, as they suffer none of the discomforts and annoyances of diplopia that adults get when the squint is developed in later life.

One eye alone is used for fixation, while the other deviates from the line of vision. This is brought about by a deficiency of either the central mechanism or the peripheral organ. There is an immediate strong tendency to suppress the image of the deviating eye to avoid diplopia. The suppression of the image of the deviating eye always leads to some degree of amblyopia. This amblyopia is not brought about by a disuse of the eye, but is instigated in the cerebral psychic center and is a purposeful neglect to avoid diplopia. Proof of this is seen in the fact that a congenital cataract which may produce disuse of the macula for many years, can be operated and immediate good vision obtained.

The amblyopia, however, is not the chief concern of the patient. The disfigurement effects are paramount. The inherent cruelty of his playmates serves to increase all his inferiority complexes, and drives him to be preyed upon by all types of cults that offer relief. Since earliest times it was—and still is in many quarters—thought to be a visitation of some angry god, and the ill luck brought on by a look from a cross-eyed person could only be averted by spitting over your shoulder or some other superstitious act.

Hippocrates, Celsus and Galen noted the deformity. A Frenchman named Ambroise Pare first studied squint, and tried to correct the condition by having the patient wear horn spectacles with central perforations, hoping to force the eyes to become straight by looking through the holes. This is still practiced by some oculists.

In 1743, Buffon inaugurated the first rational treatment by occluding the sound eye to force the squinting eye into use. After the technique of the tenotomy of the tendon of Achilles was described by Delpeck, Anthony White applied the same principle to the eye. The first successful tenotomy in the eye muscle was done by Diefenbach of Berlin in 1839. The disastrous results of indiscriminate muscle cutting induced VonGrafe in 1857 to introduce the operation of the advancement of the weaker muscles. Donders in 1864 stressed the refractive and accommodative anomalies, and insisted they be treated with glasses. In the beginning of the century Claude Worth of London called attention to the cerebral element of fusion, and instigated visual training with the amblioscope.

The types of squint are chiefly paralytic and non-paralytic. Another type which is rare is kinetic, and is produced by a sudden spasm of one of the muscles. It is caused by irritative lesions in the central nervous system.

The diagnosis as to whether a child has or has not a squint is easily made. Ordinarily it is apparent to all; but in doubt hold light or some bright object for the child to look at,

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and cover one eye and observe the other. If it moves to find the light there is squint. If it does not move then repeat the process on the other eye. If neither eye moved there is no squint. Binocular vision can also be easily tested in children by placing a prism base out before one eye, and observe if it turns in. If it does the child has binocular vision and cannot have a squint. This can be done usually as early as 4 to 6 weeks.

The child begins his desire for fusion and efforts at binocular vision as early as three weeks. This fusion tendency which is a central psychic development begins about this age, and continues to become stronger until the age of six. After this age any fusion tendency and the dependent binocular vision is hard to obtain. The degree of fusion tendency that the child has obtained begins to be testsed from nine months to two or three years. At this time the child begins to look at near objects, and his power of accommodation is brought into use.

The accommodation and converging centers being associated produce contraction of the internal recti muscles, and the greater accommodation required the greater is the stimulation to convergence.

Now if there is an abnormality of the eye such as hyperopia or astigmatism or both, causing the child to employ his accommodation in excess of the required convergence, he is then faced with a dilemma—either he does not see clearly and get the convergence necessary, or he accommodates and gets too much convergence. The desire to see clearly dominates, and he gets a convergent squint. He always uses the eye with the better vision to fixate, and squints with the other. Immediately to avoid double vision he suppresses the image of the squinting eye. For this reason this is the time to instigate treatment.

The treatment consists:

1. Immediate refraction with a mydriatic atropine. This is done by retinoscopy, and can be done as early as one to one and one-half years of age. Full correction after reducing one diopter for retinoscopy and five diopters for mydriatic, should be given. Atropine should be continued for two or three weeks so the child will want to wear the glasses. Parenthetically I might add that atropine not only acts to relax muscles of accommodation, but some systemic benefits of its anti-spasmodic action is obtained. The mother usually volunteers the information that the child is not so nervous and sleeps better. The use of atropine for relaxation of pyloric spasm has long been employed. It is of some value therefore in counteracting some of the antagonistic action of the opposing muscles in paralytic squint.

The glasses must be worn during all waking hours, even during the bath. If the child tries to push them off, tie them on with a string. Now is the time to win the cooperation of the parent, without which nothing can be accomplished. Explain that a little patience and perseverance on their part now will save untold humiliation and embarrassment for the child in the future.

After the child tolerates his glasses, and the eye still squints, continue atropine in the non-squinting eye for one month. If it still squints then complete occlusion should be started. This can be done by a small eye pad and Scotch tape, and if the skin becomes irritated use a Floyd Gibbons patch. Placing an occluder over the lens in the spectacles does not suffice, as the child peeps over it.

I might suggest that it is a good plan to tell the mother that in the use of atropine and the occlusion that you expect the good eye to begin to cross, else she will become alarmed and accuse you of ruining the good eye, for now it is crossed.

At this juncture you now have an alternating squint with good vision, with glasses, in each eye. This is the time to begin orthoptic training. Most oculists use some modification of Worth's amblioscope. Others such as Dr. George Guibor of Chicago champions the use of prisms, claiming that by their use the image can be constantly thrown nearer the macula, and instead of getting training for fifteen minutes three times a week, the child gets training all the time.

2. If no improvement is noted at the end of three months by the above efforts—surgery must be done regardless of the age of the patient. It is usually performed between the ages of three and five.

Every surgeon has his own ideas as to the type and degree of operation to be performed. Personally I use recession of the internal rectus, if the squint is less than twenty prism diopters, and if more I add the advancement of the external rectus.

In conclusion, I only want to say that to cover this subject in such a short time is impossible, as volumes have been written on it. Suffice it to say, that the earlier the patient is referred to the oculist and treatment begun, the better is the hope for success.

Plastic Surgery Group Formed

The first annual meeting of the American Otorhinologic Society for the Advancement of Plastic Surgery was held at the New York Academy of Medicine, November 12. Communications regarding membership should be addressed to the secretary, Dr. Jacob Daley, 104 E. 40th St., New York 16, N.Y.

Seasickness and Airsickness

HARRY N. HOLMES, Ph. D.

THE use of relatively large amounts of vitamin B_1 (thiamin chloride) for prevention of nausea at sea or in the air has been studied by the author for nearly two years.

Since this treatment was suggested by him to the proper authorities in Washington in July, 1942, and again later, and rejected as not justifying extensive research, it seems now that there is no need of secrecy. The very successful remedy recently announced by Dr. Best and associates of the Canadian Navy clearly is not vitamin B_1 for the author was told August 8, 1942, by Dr. Best himself that his group had not even thought of this remedy but was testing many other substances.

THIAMIN AND NAUSEA

The relation of vitamin B_1 to a few types of nausea has been observed by others for some time. Some physicians have recently been giving it by mouth, or by injection, in cases of the nausea of early pregnancy although others feel sure that the entire B complex is advisable. Dr. Rossleene Arnold Hetler, for five or six years, has had marked success in such cases by the use of B_1 alone although she took care to remedy any marked deficiency in other vitamins when indicated.

Extreme nausea in the last stages of cancer of the liver (one instance), nausea due to train travel and to auto travel, have also been greatly helped. These various nauseas did not all have a common cause and are not all to be classed as motion sickness, but the observations are not to be lightly dismissed.

Official studies emphasize the great importance of the psychological factor in motion sickness, but nevertheless there is a physiological foundation for this malady.

SEASICKNESS

Without the cooperation of the official medical advisers to the United States Navy, it was very difficult to arrange sea tests for the vitamin B_1 treatment since civilians are rarely allowed a sea voyage. However, through many friends in the Navy (names confidential) a considerable number of tests were made.

The following report is offered as interesting to the thousands of civilians who hope to cross the oceans after the war is over. Even if vitamin B_1 is not the most effective remedy, the general public is already spending many millions of dollars annually for it for other purposes and will feel familiar with it. Its use in the form of tablets to be chewed pleasantly may have attractions over capsules.

The Author

● Dr. Holmes, Oberlin, Ohio; B.S., Westminster College, Pa., in 1899; Ph.D., Johns Hopkins University, 1907; head, Department of Chemistry, Oberlin College, Oberlin.

In the author's experiments he advised taking 15 milligrams of B_1 (by mouth) daily for two days before sailing and thereafter only during rough weather.

Of the 38 men reporting (without complications of heavy drinking) only three were partial failures. In other words 90 per cent of this considerable group considered the treatment successful. Unfortunately 10 of these were on a battleship, a large carrier, and cruisers where nausea was not such a severe problem. However 24 men, habitually nauseated in rough seas, were on small, rolling and pitching craft. This carefully selected group reported in considerable detail with 100 per cent success from the treatment during very rough weather. A typical statement, from three men, was that they "felt like a million dollars".

One man, the worst case his commanding officer had ever seen, was continually nauseated on every trip, from harbor to harbor. His "cure", as he called it, was so complete that he laughed at the seaman's test of stability, watching a greasy strip of pork dangled before his eyes while the roll of the ship formed a visual background.

A thorough study of the effect of the treatment on his men by one officer during a period of three months culminated in selection of six healthy specimens, drinking little or no liquor, who were always badly nauseated in mildly rough weather. They were extreme cases, in fact. Their officer reported them "cured for good and all". Evidently early success is later reinforced by the psychology of success.

Observations on drinkers led this officer to select six other men, completely drunk after a wild night in port, for the vitamin B_1 treatment. The result was complete failure of the treatment. Summing up all his observations the officer insists that "if all seamen would lay off liquor, too much rich food and too much candy just before sailing, thiamin chloride (B_1) would be the answer to a green-faced sailor's prayer. In short, results would be 100 per cent successful".

Another officer, equipped with enough thiamin chloride for five men, crossed to Africa and re-

turned. He stated that "every man on the ship was nauseated at one time or another except those taking the vitamin B_1 tablets".

Controls, with "Placebos", were beyond the limited range of these experiments and yet at least an equal number of men on ship were compared with the 38 given the treatment. The intoxicated men, mentioned above, certainly were excellent psychological controls.

AIR SICKNESS

Too frequent nausea in early training of flyers has caused many rejections of trainees. Furthermore, glider troops and parachute troops are often nauseated in rough air, weakening their fighting powers on landing.

Experiments with preflight treatment (preferably for two days) giving 15 milligrams vitamin B_1 daily to 13 aviators resulted in 92 per cent success. In addition a physican at one camp reported success with intramuscular injections of 50 milligrams vitamin B_1 and "advised" such treatment when needed.

A notable case was that of a civilian who flew a great deal and was sick every time. After trying the oral treatment with vitamin B_1 he "was never sick again during eight months of flying all over the United States". This was about two years ago when the suggested dose was only 10 milligrams daily.

Four men in a photo unit riding large PBY planes, characterized by a "peculiar rolling motion", had many times been violently sick in rough air. As a result of 15 milligrams vitamin B_1 treatment not one was ill again in rough air.

The medical officer at another camp was sufficiently encouraged to advise further large-scale experiments. He had prepared four aviators by three-day treatments of 15 milligrams vitamin B_1, using a fifth as control with soda tablets. All subjects had been sick on all previous long flights (thirty to forty-five minutes). The final test fiight of two and a half hours in extremely rough weather was so trying that "75 per cent of the regiment was sick". Naturally the control outdid his previous nausea records. One failure was reported with two remarkable successes and one moderate success. The last case was that of the medical officer himself who elected to take his three days' treatment at the last minute thus failing to give the vitamin a fair chance.

CONCLUSIONS

The limited studies above reported are obviously far from ideal in number (only 51) and in controls so they are submitted only as suggestive of further research by the medical profession. No doubt the vitamin B_1 treatment has been tried and rejected by a number of physicians because of use of too low a dosage. The indications are that at least 15 milligrams daily, beginning two days before sailing or flying, should be tried.

A naval medical officer writes that "the B complex is sometimes effective for the nausea of radiation sickness". A biochemist adds that vitamin B_1 treatment of certain types of nausea is most effective only when there is no marked deficiency in other vitamins. The field for research is promising.

Chemotherapy in Gonorrhea

To make it possible for the medical profession to apply new knowledge in the chemotherapy of gonorrhea promptly, a rapid appraisal of the sulfonamides most commonly used in gonorrhea therapy has been conducted by the American Neisserian Medical Society and the U.S. Public Health Service.

Appraisal is conducted by pooling the current case reports of a group of approximately 35 co-operating clinics. The cumulative results of the study thus far, in which more than 2,500 cases reported have been appraised, indicate that sulfathiazole is the most effective cure for gonorrhea. Of patients to whom it was administered, 86 per cent became asymptomatic with or without becoming bacteriologically negative by the end of the third week, and only 1.1 per cent experienced severe reactions.

The following summarizes the findings for the entire period of the study, which has been conducted for more than three years.

DISAPPEARANCE OF SYMPTOMS

	2 weeks	3 weeks	4 weeks	Severe reactions
Sulfadiazine	88%	84%	84%	1.6%
Sulfathiazole	83%	86%	86%	1.1%
Sulfapyridine	79%	85%	83%	9.1%
Sulfamerizine	62%	68%	72%	1.1%
Sulfanilamide	55%	62%	65%	—

—Military Surgeon, Dec., 1943.

Otolaryngology Refresher Course

The Department of Otolaryngology, University of Illinois College of Medicine, announces its spring refresher course, to be held at the college in Chicago, March 20 to 25, inclusive, 1944. The course will be largely didactic, but some clinical demonstrations have been included. It is intended primarily for specialists, who under existing conditions, are able to devote only a brief period to postgraduate review study. The fee is $50.00. Registration will be limited. In letter requesting application, state school and year of graduation; also give details concerning specialty training and experience. Address—Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago, Illinois.

Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

EXACT comparisons among various sanatoria as to results of treatment are impossible, particularly now when World War I veterans admitted are older men, usually with chronic disease. Of recent admissions, only 4 per cent were "incipient" cases, 22 per cent "moderately advanced," and 74 per cent "far advanced". Even so there is a painful contrast between the results with veterans and those achieved in well managed state, municipal, and private sanatoria. In a 1933-34 survey of tuberculosis hospitals and sanatoria in the United States by the American Medical Association, patients discharged with tuberculosis "arrested," "apparently arrested," or "quiescent," accounted for 29 per cent of all discharged. Among Michigan State sanatoria from 1930 to 1934 discharges included 61 per cent in these three groups. At Mount McGregor Sanatorium of the Metropolitan Life Insurance Company, of males discharged between 1919 and 1936, and excluding incipient cases, 48 per cent were in comparable categories. Even for cases far advanced on admission, the proportion was 34 per cent.

This deplorable situation among tuberculous veterans has not developed from lack of desire to help the men. Everyone concerned aimed at optimum care. *The chief failure was by legislators and others interested in veteran welfare to appreciate fundamental conditions necessary for effective treatment.* In part, outside pressure was brought to bear to liberalize financial provisions. These measures actually have minimized effective control over the movement of the tuberculous. Veterans, not subject to ordinary hospital restrictions, come and go almost at will, regardless of their condition and against medical advice. Patients have been readmitted as many as 24 different times. Six to 8 admissions of the same man are common despite official effort to educate and persuade patients to complete their hospital care, and measures to exclude offenders from immediate rehospitalization. Much of the discipline essential to success in treating tuberculosis is lacking. Indeed, laws and practices have so evolved that it often financially benefits men to leave the hospital or avoid it altogether. This creates an impossible situation, undermining morale of veterans and professional staff alike.

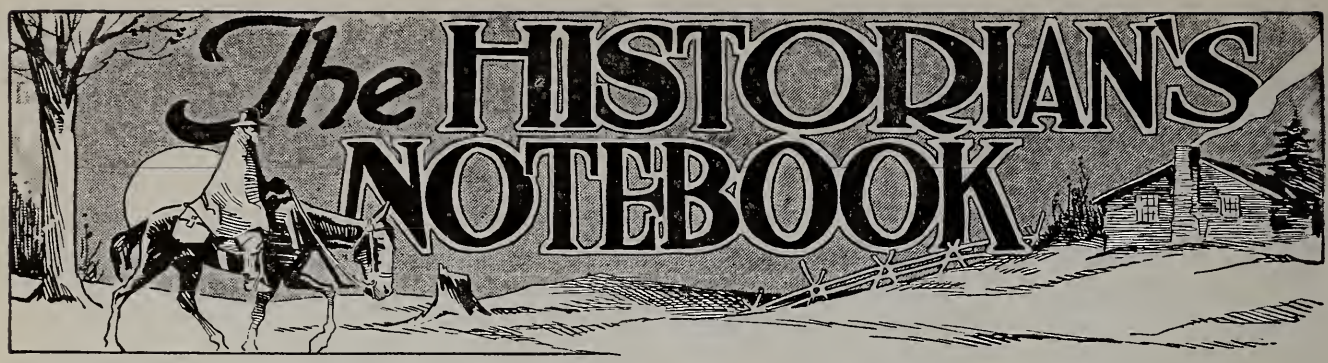
More serious than mere failure to rehabilitate the patient, discharge before cure exacts its toll on the nation. It has allowed thousands with communicable tuberculosis to return to civilian communities, to live at home or travel about under little or no medical supervision. State and local health officers have assumed little responsibility for men traditionally regarded as wards of the federal government. Few patients have recovered; most have constituted an army of discouraged men spreading tuberculosis in their home communities.

Administration authorities and veterans' leaders are recognizing the need for a remedy, beginning with a drastic change in viewpoint. Specific improvements are being considered and necessary legislative measures will be debated. The American Legion is launching a campaign through its local branches to see that veterans resume and continue hospital treatment until discharged with medical approval.

What is to be done? First, new controls must render liberal benefits medically effective, preventing the drifting of tuberculous veterans until the disease is "arrested" or, at least, not a menace.

Second, the medical profession must cooperate with the Veterans' Administration in the follow-up of tuberculous ex-patients. The Administration has indicated that it will release information to state and local health officers, and routines for getting such reports are imperative. Men still in need of sanatorium care who will not stay in veterans' institutions should be hospitalized in state or local sanatoria, with legal power invoked where necessary. Each man's circle of contacts should be thoroughly combed for additional cases.

Finally, a genuine effort must be made to protect the large crop of tuberculous veterans inevitable from the present war. It is likely that the Veterans' Administration will function under regulations and procedures governing the care of veterans of World War I. Already, many of the tuberculous veterans of the new war show the same restlessness and abandonment of hospital care which have produced calamitous results among the older men. With new cases already numerous, the stage may be set for another great medical tragedy. Lack of discipline and mistaken generosity may not only take their toll of young men who deserve to get well and resume useful lives, but may seriously delay control of tuberculosis in the general population—unless we act.—Function of the Health Officer in the Control of Tuberculosis among Veterans, Louis I. Dublin, Ph.D., Amer. Jour. of Pub. Health, Dec., 1943.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

Botanic Medicine in the Western Country

PHILIP D. JORDAN, PH.D., Oxford, Ohio

(Continued from February issue.)

When the botanic physician reached his third cardinal principle he could select from a long list of remedies which would scour the stomach and move the bowels. As a matter of fact, it made little difference whether he gave a costic frontiersman the bark of the roots of the bayberry, the root of the white pond lily, the inner bark of the hemlock, the root of the marsh rosemary or the bark, leaves, and berries of three species of sumach. All worked equally well if given frequently enough and in sufficiently large doses. Sometimes several were mixed together as in this prescription which produced violent results. "Take bayberry root bark, white pond lily root, and the inner bark of the hemlock, equal parts of each pounded and well mixed together; steep one ounce of the powder in a pint of boiling water, and give for a common dose a common wine glass full, sweetened." The explosive results of this purgative left even a stalwart frontiersman with a cleansed system, but as weak and trembling as a scared possum.

Therefore, it behooved the backwoods, botanic doctor to correct the bile and sweeten the digestion if his patient were to be restored to health. This toning-up procedure was done with more vegetable preparations, including poplar bark, bitter root bark, and golden seal which also was called Ohio Kercuma, orange root, tumeric root, yellow puccoon, eye balm, and Indian plant. If the patient failed to respond he was given a simple sugar syrup prepared with peach meats or with wild cherry stones. Half a wingless full two or three times a day was practically guaranteed to have a man swinging an ax within a week.

But the course of Thomsonian medicine had not run its full length. It was still necessary to accomplish the sixth objective, namely, to "remove pain, prevent mortification, and promote a natural heat". This meant that the convalescent patient embarked upon a long program of tonic-taking. The tonic had its advantages. It was prepared as follows: "Take one gallon of good fourth proof brandy, one pound of gum myrrh pounded fine, one ounce of capsicum, and put them into a stone jug, and boil it a few minutes in a kettle of water, leaving the jug unstopped. When settled, bottle it up for use." The dose was from one to two teaspoonfuls. Of course, this tonic would have been equally effective had all the ingredients been removed except the brandy, although it must be said that the capsicum did contribute some heat.

No one was better qualified to attest the severity of a course of treatment prescribed by a pioneer doctor than one who experienced it. A settler who suddenly acquired an ailment he was unable to diagnose sent for the family physician. The doctor came several miles on horseback,

"with his saddlebags of medicine, comprising tartar emetic, calomel, jalap, caster oil, salts . . . and a lancet. He had me to thrust out my tongue for inspection, then felt my pulse. He said I was very bilious and had a high fever. He proceeded to give me an emetic, then had me to take calomel and jalap, for a physic. He returned two days after, found me still bad and administered more emetics and physic, and in addition bled me till I fainted and was carried to bed. He said he was 'taking me through a course of medicine to prostrate the system.' The doctor continued his remedies for about two weeks. He changed his medicines to something else . . . it made me slobber like a horse that ran on a white cloverfield. I was now reduced to a mere skeleton; life was about dispaired of. But sure enough the fever was broken, for there was little left of me to create a fever."

However, a course of the brandy tonic, as conceived by Thomson, soon put him on his feet again.

It was a relatively easy matter for the botanic physician, tutored in the botanic school, to accumulate a supply of drugs. The family of the

patient might gather the plants. Or, if the physician had to supply them, he might collect them himself, send his medical student for them, or purchase them at fairly reasonable rates. The society of Shakers in Warren county could provide a "variety of medicinal plants—native and exotick," and there were other private sources. One Ohio doctor reported, "I got my radix seneke for 50 cents per pound; my Virginia snakeroot for 25 cents; wild cucumber fruit for 50 cents per bushel, and other articles at similar prices." In 1823, a Cincinnati druggist was retailing to the profession English epsom salts at 37½ cents per pound; Peruvian bark at 12½ cents an ounce; and Glauber salts at 18¾ cents per pound.

Thomsonianism was to make its influence felt from the Atlantic Coast through the Ohio country into the trans-Mississippi and trans-Missouri West. Hundreds of eager men and women—pioneers, farmers, merchants, and professional men—came to look upon Thomson's system of botanic drugs and steam baths as positive boons to healthful living. The medical profession hated him.[22] In 1809, he was indicted and tried at Salem, Massachusetts, on the charge of murdering a patient, but was acquitted. On March 3, 1813, he received from the Patent Office of the United States his first protection on his system and on January 28, 1823, was given a revised patent.[23] It was Thomson's plan to permit groups to organize throughout the country and to practice accordingly.[24] The movement spread rapidly and became popular in the South and West where thousands endorsed the use of lobelia, capsicum, and steam baths. During the forties, the State of Alabama legalized Thomsonian practice.[25] By 1835, the governor of Mississippi had stated publicly that "one-half the people of the state relied upon Thomsonianism".[26] Four years later Thomson claimed three million adherents in the United States.

Ohio, situated advantageously between the settled East and frontier West, embraced the botanic system with enthusiasm. Individuals such as Horton Howard (who sold four thousand rights in Ohio and neighboring states in less than four years), Alva Curtis (who secured a charter for the Literary and Botanico-Medical Institute of Ohio), and Samuel Robinson (who wrote one of the most passionate defenses of Thomsonianism)[27] kept public interest aroused. As a matter of fact, the Buckeye State became the major publishing center of the movement. Not only were several editions of Thomson's books printed in the state,[28] but also two journals, the *Thomsonian Recorder* and the *Botanico-Medical Recorder*. Both were edited by Curtis.[29]

Although the enterprising Thomson systematized botanic medicine, he, of course, was not the first to recognize the therapeutic value of plants and herbs. Jacques Cartier, the intrepid Mariner of St. Malo, successfully used a decoction made from the bark of the hemlock in the treatment of scurvy in New France in 1536.[30] André Michaux, a French botanist and clever espionage agent, traveling through Ohio, Kentucky, and Tennessee in 1795, was alert to the medical properties of American plants. His son, François André Michaux, continued the interest of his father. The abbreviation, "Michx." and "Michx.f.," appended to the scientific names of many American plants indicate the activity of both father and son in early botanical exploration. Two other active botanists of the western country were Charles Wilkins Short (1794-1863) and Robert Peter (1805-1894) who made many solitary trips through the "natural flower-gardens" of the Kentucky Barrens.[31] Constantine Rafinesque, professor of natural science at Transylvania University, also was alert to the medicinal value of native plants.

So intense did the interest in native, western flora become that in 1834 the *Western Journal of the Medical and Physical Sciences* published an extensive synopsis together with complete directions for collecting and preserving botanical specimens.[32] Two years later, John L. Riddell, professor of chemistry and lecturer on botany in the Cincinnati Medical College, printed a supplementary catalogue of Ohio plants.[33] By this time—the eighteen-thirties—even old-school physicians had become impressed with the use of botanic medicine, although they still clung to their laudanum and calomel.

In 1838, Daniel Drake issued a public notice requesting that Ohioans send him "Specimens of plants, known or supposed to be medicinal, or poisonous, or useful in the chemical arts."[34] Even the pharmacopoeia of the United States and subsequent materia medicas had become somewhat vegetable.[35] Graduates from approved botanic medical colleges were following the push and ebb of the frontier. At Kanesville, jumping-off place for thousands of emigrants hitting the California trail and headquarters of the Mormon Battalion, a botanic physician advertised that he was "competent to manage most diseases incident to the climate".[36] It seemed as if the pioneer had won his long-fought battle against mercurial drugs, blood-letting, and heavy doses. But already a new pharmacology was developing which was given impetus by the War Between the States, was stimulated further by scientific researches in France and Germany, and, by 1890, in most locations in the United States, was to supplant the vegetable practice so popular during the earlier decades of the century.

FOOTNOTES

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3. Robert Baird, View of the Valley of the Mississippi,

or, the Emigrant's and Traveller's Guide to the West (Philadelphia, 1834), 81, 83, 84, 85, 86.

4. John B. Newall, Sketches of Iowa, or, the Emigrant's Guide (New York, 1841), 25.

5. Oliver G. Steele, Steele's Western Guide Book and Emigrant's Directory (Buffalo, 1849), 16.

6. E. Dana, Geographical Sketches on the Western Country: Designed for Emigrants and Settlers (Cincinnati, 1819), 32.

7. William Darby, The Emigrant's Guide to the Western and Southwestern States and Territories (New York, 1818), 40-1.

8. ....., The Emigrant's Guide, or Pocket Geography of the Western States and Territories (Cincinnati, 1818), 8.

9. Thwaites, op. cit., XXVII, 95.

10. See, for example, L. Meeker Day, The Botanic Family Physician, or, the Secret of Curing All Diseases (New York, 1833); J. Kost, The Practice of Medicine, According to the Plan Most Approved by the Reformed or Botanic Colleges of the U. S., Embracing a Treatise on Materia Medica and Pharmacy . . . Designed Principally for Families (Mt. Vernon, Ohio, 1847); John C. Gunn, Gunn's Domestic Medicine, or, Poor Man's Friend, Showing the Diseases of Men, Women and Children, and Expressly Intended for the Benefit of Families (Madisonville, Tenn., 1834); for home nursing care see, for example, Mackenzie's Five Thousand Receipts In All the Useful and Domestic Arts (Hamilton, Ohio, 1830), and Miss Beecher's Domestic Receipt-Book (New York, 1863); for obstetrics see, for example, Samuel Bard, A Compendium of the Theory and Practice of Midwifery, Containing Practical Instructions for the Management of Women During Pregnancy, in Labour, and in Child-Bed (New York, 1819) and Wm. P. Dewees, A Compendious System of Midwifery, Chiefly Designed to Facilitate the Inquiries of Those Who May be Pursuing This Branch of Study (Philadelphia, 1828).

11. Philip D. Jordan, "The Treatment of Gun-Shot Wounds in Frontier Ohio," The Ohio State Medical Journal (Columbus), Vol. 39 (1943), 844-6.

12. Samuel Robinson, A Course of Fifteen Lectures on Medical Botany (Columbus, Ohio, 1829), title page.

13. John A. Brown, Quackery Exposed!!! Or a Few Remarks on the Thomsonian System of Medicine (Boston, 1833), title page.

14. Richard Carter, A Short Sketch of the Author's Life and Adventures From His Youth Until 1818, in the First Part; in Part the Second, A Valuable Vegetable Medical Prescription With A Table of Detergent and Corroborant Medicines to Suit the Treatment of the Different Certificates (Versailles, Ky., 1825), I, 156.

15. F. Garvin Davenport, Ante-Bellum Kentucky (Oxford, Ohio, 1943), 88.

16. Thwaites, op. cit., XXI, 95.

17. From the manuscript medical notebooks of Peter S. Townsend, a medical student at the College of Physicians and Surgeons, University of the State of New York, 1813-17. In the Pennypacker Collection, The East Hampton Library, East Hampton, Long Island.

18. "The Gold Seekers of California," Illustrated London News (London, England), XVI (1849), 83.

19. I. H. Pierce and Philip D. Jordan, "Materia Medica from Ohio to California," The Ohio State Medical Journal (Columbus) Vol. 37 (1941), 871-5.

20. "Calomel," The Athenian (Athens, Alabama), March 5, 1820; almost the same song under the title, "Go Call the Doctor and Be Quick," was a favorite upon the program of the famous Hutchinson Family of singers from New Hampshire. See Philip D. Jordan and Lillian Kessler, Songs of Yesterday (New York, 1941), 234-7.

21. Peter Smith, The Indian Doctor's Dispensatory (Cincinnati, 1813), passim.

22. Sumner Stebbins, "Address in Refutation of the Thomsonian System of Medical Practice Delivered in the Lecture Room of the Chester County Cabinet of Natural Science, West Chester, Pennsylvania, December, 1836," The Eclectic Journal of Medicine (Philadelphia) I (1837), 318-24.

23. Dictionary of American Biography, XVIII, 488-9.

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25. Richard H. Shryock, The Development of Modern Medicine (Philadelphia, 1936), 254.

26. Frederick C. Waite, "Thomsonianism in Ohio," Ohio State Archaeological and Historical Quarterly (Columbus) XLIX (1940), 327.

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28. See, for example, Samuel Thomson, A Narrative of the Life and Medical Discoveries of Samuel Thomson; Containing An Account of His System of Practice and the Manner of Curing Disease with Vegetable Medicine Upon a Plan Entirely New (Columbus, 1827); id., New Guide to Health; or, Botanic Family Physician (Columbus, 1827). These were both fourth editions.

29. Otto Juettner, Daniel Drake and His Followers (Cincinnati, 1909), 110-11; Jonathan Forman, "Dr. Alva Curtis in Columbus, The Thomsonian Recorder and Columbus' First Medical School," Ohio State Archaeological and Historical Quarterly (Columbus) LI (1942), 332-40.

30. Philip D. Jordan, "Jacques Cartier—First Pathologist of New France and of Ohio," The Ohio State Medical Journal (Columbus) Vol. 38 (1942), 1137-8.

31. Charles W. Short, A Sketch of the Progress of Botany in Western America (Lexington, 1836), 346-7.

32. John L. Riddell, "Western Flora," Western Journal of the Medical and Physical Sciences (Cincinnati) Whole XXXI (1834), 329-74.

33. John L. Riddell, A Supplementary Catalogue of Ohio Plants (Cincinnati, 1836).

34. "Journal of the Proceedings of the Medical Convention of Ohio at its Second Session, Begun and Held in the City of Columbus on the First Day of January, 1838," Western Journal of the Medical and Physical Sciences (Cincinnati) Second Hexade, V (1838), Supplement, appendix.

35. See, for example, Jacob Bigelow, A Treatise on the Materia Medica, Intended as A Sequel to the Pharmacopoeia of the United States (Boston, 1822); H. M. Edwards and P. Vavasseur, A Manual of Materia Medica and Pharmacy (Philadelphia, 1829); Morris Mattson, American Vegetable Practice (Boston, 1841); Martyn Paine, Materia Medica and Therapeutics (New York, 1848); Henry Beasley, The Medical Formulary: Comprising Standard and Approved Formulae for the Preparation and Compounds Employed in Medical Practice (Philadelphia, 1856); Alfred Stille, Therapeutics and Materia Medica (Philadelphia, 1874.)

36. The Frontier Guardian (Kanesville, Iowa). Feb. 7, 1849; see also Burlington (Iowa) Daily Telegraph, June 11, 1853, in which Dr. G. W. Snyder, botanic physician, thanks citizens for their patronage.

In addition to the footnotes cited. Dr. Jordan also referred to a master's thesis, "The Frontier Doctor in Ohio," written by Paul M. Davis under Dr. Jordan's supervision in 1940. The table of doses from Gunn's Domestic Medicine shows in detail the prevailing nineteenth-century tendency to administer large quantities and illustrates Dr. Oliver Wendell Holme's sarcastic delineation of the American's greed of medicine. "How could a people," exclaimed Holmes, "who have had a revolution once in four years, who have contrived the bowie-knife and the revolver, who have chewed the juice out of all the superlatives in the language in Fourth of July orations, and so used up its epithets in the rhetoric of abuse, that it takes two great quarto dictionaries to supply the demand; which insists in sending out yachts and horses and boys, to outsail, outrun, outfight and checkmate all the rest of creation—how could such a people be content with anything but heroic practice? What wonder that the stars and stripes wave over doses of ninety grains of sulphate of quinine, and that the American eagle screams with delight to see the three drachms of calomel given at a single mouthful?"

The Medical Examiner System; Historical

The first change in the office of coroner in America was made in 1877 when the Commonwealth of Massachusetts dropped the title of coroner and created the title of medical examiner. The magisterial duties of the coroner were transferred to the district court and all inquests were held by it, the medical examiner presenting his testimony as a witness at the inquest. Somewhat similar changes were made subsequently in New York City in 1915, later (1927) in Essex County, New Jersey, and most recently (1939) in the State of Maryland. The tendency has been, in making such changes, to abolish the coroner as a constitutional officer, transferring these duties to already constituted judiciary authorities, and to provide for the appointment of a medical practitioner by statute. The earliest change in the law stipulated that the examiner be an able practitioner of medicine; more recent changes required that he be a pathologist.—Herbert S. Breyfogle, M.D., St. Louis, Mo.; Jour. Missouri Med. Assn., Vol. 40, No. 12, Dec., 1943.

Six Outstanding Out-of-State Guest Speakers Accept Places on Program for Annual Meeting, May 2-4

APPEARING on the Cover Page of this issue are photographs of the six out-of-state guest speakers who will participate in the 1944 Annual Meeting of the Ohio State Medical Association, May 2, 3 and 4, Neil House, Columbus.

The State Association is fortunate in having been able to obtain such outstanding authorities for the Columbus meeting. Members of the Association should plan to be on hand to hear their addresses. The complete program for the Ninety-Eighth Annual Meeting will be published in the April issue of *The Journal*—a program which will compare favorably with the excellent programs presented at pre-war meetings.

Following are thumb-nail sketches of the guest speakers:

Dr. Andrew C. Ivy, Chicago, is Nathan Smith Davis Professor of Medicine, Northwestern University Medical School; fellow, American College of Physicians, American Medical Association, American Gastroenterological Association, American Physiological Society and Chicago Institute of Medicine; consultant, Passavant and Wesley Memorial hospitals. He will address two general sessions and participate in the Quiz-Discussion Session on Medicine. Subjects: "Functional and Organic Diseases of the Gastro-Intestinal Tract: Physiological and Medical Considerations" and "Cirrhosis of the Liver".

Dr. Arthur W. Allen, Boston, is lecturer in surgery, Harvard Medical School and chief, East Surgical Service, Massachusetts General Hospital; fellow, American College of Surgeons, American Medical Association, American Surgical Association, International Society of Surgery, Society of Clinical Surgery, and Boston Surgical Society. He will address two general sessions and participate in the Quiz-Discussion Session on Surgery. Subjects: "Functional and Organic Diseases of the Gastro-Intestinal Tract: Surgical Considerations" and "Gallbladder Diseases".

Dr. Anton J. Carlson, Chicago, is professor emeritus of physiology, University of Chicago, and one of the world's leading physiologists. He will address a general session. Subject: "Fatigue".

Dr. Edward L. Turner, Nashville, is president and professor of medicine, Meharry Medical College; fellow, Association of American Physicians, American College of Physicians, Central Society for Clinical Research, Society for Experimental Biology and Medicine, American Medical Association; former chief of medical service and professor of medicine, American University of Beirut. He will address a general session. Subject: "The Dysenteries".

Dr. Mervin H. Knisely, Chicago, is assistant professor of anatomy, University of Chicago, and visiting professor, University of Tennessee Medical School. He will address a general session. Subject: "Malaria", supplemented by motion pictures on "Knowles Malaria in Phesus Monkeys".

Dr. Paul H. Holinger, Chicago, is assistant professor of laryngology, University of Illinois College of Medicine; attending bronchologist, Children's Memorial, St. Luke's, and Research and Educational hospitals, Chicago; fellow, American College of Surgeons, American Medical Association, American Broncho-Esophagological Association, American Laryncological, Rhinological and Otological Society and American College of Chest Physicians. He will address the Section on Eye, Ear, Nose and Throat participate in the Quiz-Discussion Session on Eye, Ear, Nose and Throat. Subject: "Cine-Bronchoscopy — Kodachrome Visualization of Endobronchial Pathology".

Developing Plans for A. M. A. Session

A prospective feature of the 1944 annual session of the American Medical Association, to be held in Chicago, June 12-16, is a national medical war meeting at which there will be present distinguished representatives of the medical military services of the United Nations as well as other eminent speakers. Plans are being made also for many round table and panel discussions and for symposiums on subjects of current interest, including such topics as the amino acids and the vitamins in nutrition, the dysenteries, postwar trends in obstetrics, industrial ophthalmology, new advances relating to the uses of penicillin and the sulfonamides, head injuries, asphyxia, the neuroses, fatigue, nutrition and rehabilitation, new aspects of endocrinology and urology, malaria and other tropical diseases, blood transfusion and new advances with blood and blood substitutes. A special section will be devoted to the interests of the general practitioner, and section officers have been appointed to work out a program designed particularly for this group.

Since the transportation and hotel facilities of Chicago are likely to be taxed to the utmost under war conditions, those who plan to attend the annual session should make the necessary reservations just as soon as the official announcement appears in the Organization Section of *The Journal of the A.M.A.* and in the advertising pages in the near future.

QUESTIONS . . . . . .

● Which you want answered at the quiz-discussion sessions at the 1944 Annual Meeting of The Ohio State Medical Association, May 2, 3 and 4, Neil House, Columbus, should be submitted immediately.

Turn to Following Page for Personnel of Panels Which Will Answer Questions at the Quiz-Discussion Sessions on May 3

USE THIS BLANK FOR YOUR QUESTION

Ohio State Medical Association
79 East State Street
Columbus 15, Ohio

I expect to attend the Quiz-Discussion Session on.....
(See Opposite Page for List

.....on May 3, at the 1944 Annual Meeting, Columbus, and
of Quiz-Discussion Sessions)
would like to have the following question answered by the panel discussants at that Session:

Question:_____

. . . . . ANSWERS

See Preceding Page for Blank To Be Used In Transmitting Quiz-Discussion Questions for Sessions on May 3 at the 1944 Annual Meeting

● To questions submitted by members will be given by selected panels at the quiz-discussion sessions on May 3, a feature of the 1944 Annual Meeting, The Ohio State Medical Assn., Neil House, Columbus.

QUIZ-DISCUSSION SESSIONS AND NAMES OF DISCUSSANTS

Medicine, Including Tropical Medicine, Psychiatry, and Occupational Diseases

Homer D. Cassel, M.D., Dayton, *Chairman*
Andrew C. Ivy, M.D., Chicago, *Guest Speaker*
Russell L. Haden, M.D., Cleveland
Marion A. Blankenhorn, M.D., Cincinnati
William M. German, M.D., Cincinnati
Bruce K. Wiseman, M.D., Columbus
John Romano, M.D., Cincinnati

Surgery, Including Orthopedic and Industrial Surgery

Louis G. Herrmann, M.D., Cincinnati, *Chairman*
Arthur W. Allen, M.D., Boston, *Guest Speaker*
Joseph A. Freiberg, M.D., Cincinnati
George M. Curtis, M.D., Columbus
Edward J. McGrath, M.D., Cincinnati
John W. Holloway, M.D., Cleveland
W. A. Altemeier, M.D., Cincinnati

Eye, Ear, Nose and Throat

Fred W. Dixon, M.D., Cleveland, *Chairman*
Paul Holinger, M.D., Chicago, *Guest Speaker*
Horace E. Mitchell, M.D., Lakewood
M. Paul Motto, M.D., Cleveland
Henry Goodyear, M.D., Cincinnati
A. D. Frost, M.D., Columbus

Hygiene and Public Health

R. H. Markwith, M.D., Columbus, *Chairman*
Carl A. Wilzbach, M.D., Cincinnati
W. D. Bishop, M.D., Greenville
Christopher Leggo, M.D., Columbus
R. E. Heering, M.D., Columbus
Susan P. Souther, M.D., Columbus

Obstetrics and Gynecology

Tom F. Lewis, M.D., Columbus, *Chairman*
Charles W. Pavey, M.D., Columbus
Martin W. Diethelm, M.D., Toledo
Wilbur A. Ricketts, M.D., Dayton

Pediatrics

Earl H. Baxter, M.D., Columbus, *Chairman*
A. A. Weech, M.D., Cincinnati
James G. Kramer, M.D., Akron
Sterling H. Ashmun, M.D., Dayton

Second Call for Hotel Reservations for the 1944 State Association Annual Meeting, May 2, 3 and 4, Columbus!

DON'T delay any longer making your request for hotel reservations for the Ninety-Eighth Annual Meeting of the Ohio State Medical Association, Tuesday, Wednesday and Thursday, May 2, 3 and 4, at the Neil House, Columbus.

In order to assure yourself of the type of accommodations you will require, send in your request for reservations **immediately** to the hotel of your choice.

Requests for reservations should be addressed directly to the management of the hotel selected.

Check the accompanying list of Columbus hotels, their locations and rates! Make your choice! Fill in the blank accordingly! Mail it **now**!

NAME AND LOCATION	No. of Rooms	Single	Double	Double Twin Beds	Suites
NEIL HOUSE (Headquarters Hotel) 35 South High St.	665	$4.50-7.00	$5.50-9.00	$6.50-11.00	Rates on request
DESHLER-WALLICK Broad and High Sts.	1000	3.50-8.80	5.50-11.00	6.50-13.30	$8.80 to $26.40
FORT HAYES 31 W. Spring St.	350	3.00 and up	4.50 and up	5.00 and up	7.00-18.00
CHITTENDEN High and Spring Sts.	275	2.50-3.00	3.00-4.00	3.50-6.00	
SENECA 361 E. Broad St.	250	2.50-3.50	3.75-5.00	5.00-5.50	3.75 to 8.00 (single) 5.50 to 10.00 (double)
SOUTHERN High and Main Sts.	250	2.50-3.00	3.50-4.50	4.00-4.50	
VIRGINIA Third and Gay Sts.	150	2.20 and up	3.30 and up	4.40 and up	
BROAD-LINCOLN 631 E. Broad St.	140	2.00 and up plus 10%	3.00 and up plus 10%	4.50 and up plus 10%	3.50 and up plus 10%

HOTEL RESERVATION BLANK

Mail this coupon to hotel selected

Manager_____ Hotel, Columbus, Ohio.

You are requested to reserve the following accommodations during the period of the Ninety-Eighth Annual Meeting of the Ohio State Medical Association, May 2, 3 and 4, 1944, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double room with bath Price:_____

☐ Twin Bed Room with bath ☐ Suite

Arriving May_____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION.

Name _____

Address _____

_____

Plan to Pay Benefits to Ohioans Unable to Work Because of Illness Studied; Compulsory Hospital Insurance Program Recommended by Rhode Island Governor

INSURANCE to cover Ohio employes unable to work because of illness is being studied by the Advisory Council of the Ohio Bureau of Unemployment Compensation.

The Governor of Rhode Island, which state has a program of this kind in operation, has appointed a commission to work out the details of a proposed compulsory hospital insurance program.

The Council of State Governments through its Commission on Interstate Cooperation has sent copies of the Wagner-Murray-Dingell Bill to each governor, urging him "to study it with state welfare and compensation officials".

President Roosevelt in his message to the second session of the Seventy-Eighth Congress referred to "adequate medical care and the opportunity to achieve and enjoy good health" in propounding a "Second Bill of Rights".

In its eighth annual report the Social Security Board recommended extensive revisions and expansions in the social security program, stressing the belief that "provisions for health and medical care have an important place in any comprehensive and adequate program of social security".

THESE ARE SIGNIFICANT ITEMS

These news items are evidence that study of, perhaps action on, proposals to modify and expand present methods of distributing medical and hospital services will not be delayed until the conclusion of the war. Their implication is that the medical profession must concern itself more directly with such present-day activities.

Following are excerpts from an article published in the *Columbus Dispatch* regarding the studies by the Ohio Bureau of Unemployment Compensation advisory group of disability insurance:

"While no member of the seven-member council has made formal expression as to whether he favors such a program, Dr. Edison L. Bowers, chairman of the department of economics, Ohio State university and vice chairman of the council, said that research data will be submitted to Governor Bricker later 'with or without a recommendation'.

"The advisory council functions under state law, conducting research and making recommendations to the BUC administrator, governor, legislature or BUC board of review, if they feel changes are needed in the unemployment compensation law.

"Dr. Bowers emphasized that the council's study of sickness insurance was undertaken because of its possible relationship to the unemployment compensation program.

"He also asserted that one factor responsible for the research activity is the fact that legislation is pending in congress to federalize all social agencies and establish federal sickness insurance, socialized medicine, hospitalization and related subjects.

"Before sickness insurance could become a possibility in Ohio, a law would have to be passed modifying the unemployment compensation insurance act.

"Only one state, Rhode Island, now has state administered sickness insurance. There, the program functions exactly as unemployment compensation insurance, a worker who becomes ill being granted compensation under the same rules as if he were eligible for unemployment benefits.

"Another state, New Hampshire, also is giving consideration to sickness insurance and only recently a special commission returned a favorable report.

"In Rhode Island the employe has been paying one per cent of his salary into the sickness insurance fund and one-half of one per cent into the unemployment compensation fund. A bill is now pending which would eliminate the payment to the unemployment compensation fund, and diverting to the sickness insurance fund the one and one-half per cent total.

HOW PLAN WOULD FUNCTION

"As explained by Ohio BUC officials, the sickness insurance would be administered as follows, if it should become a reality and should be patterned after the Rhode Island set-up:

"Workers who become ill would be eligible for sickness insurance after two weeks, with maximum payments of $16 a week which could be made for 18 weeks. These provisions would be the same as those in the unemployment compensation law.

"No worker would be eligible for workmen's compensation or unemployment compensation when receiving sickness compensation. To be eligible now for unemployment compensation a worker must be available and willing to work. To be eligible for sickness compensation he would have to be unable to work because of illness.

"Besides Dr. Bowers, other members of the council include John F. Burns, business representative, Cleveland Building and Construction Trade Council; Albert F. Dawson, Cincinnati Gas & Electric Co.; Rabbi Armond E. Cohen, Cleveland; John E. Breidenbach, Dayton, vice president of Ohio State Federation of Labor; Ralph H. Miner, Akron, Goodyear Tire & Rubber Co., and William C. Safford, Cincinnati, vice president Western & Southern Life Insurance Co."

RHODE ISLAND PROPOSAL

According to the *Washington News Letter on Social Legislation*, Governor J. Howard McGrath in a message to the Rhode Island Legislature made these comments regarding a proposed compulsory state-wide hospital insurance program:

"Perhaps this great country would not yet have embarked upon a broad program of social

legislation if the initiative were not taken by the Federal government in the depths of the depression. For that initiative and for all the good that it has produced, we are mindful and grateful, as we have been cooperative. We believe, however, that many of these programs could be operated better by the States where the details of the system could be integrated efficiently to the economy and needs of local conditions. . . . We must begin to think ahead of the Federal government with respect to future social security programs, or stop talking about State's rights.

"Apropos of this belief which I have expressed on several public occasions I have tried to stimulate thinking and study and cooperation in Rhode Island, to the end that we might organize our own programs. I asked the Department of Social Welfare some months ago to give serious consideration to a program that would better secure the health of our people so that we could get away from one of the great causes that lead people eventually to public assistance rolls.

PROFESSION ASKED TO ASSIST

"By these studies, which are continuing, we conclude that serious illness in a family resulting in heavy hospital costs is one of the major threats to the security and economic well being of the people. Your far-seeing wisdom of establishing a Cash Sickness Insurance Law for Rhode Island only partially meets this threat.

"Leaders in the field of medicine, hospitalization, persons interested in hospital insurance and many other civic-minded citizens have taken part in our inquiries with respect to the question of adequate hospitalization at minimum costs for our citizens. The study was commenced and proceeds upon the broad principles which I hope may be the foundation of future social security programs. I might outline those principles broadly as follows:

"(1) Utilization of existing facilities wherever possible, always avoiding the expense incident to the creation of new and duplicate facilities.

"(2) Compliance with the principles and practices of the professions or institutions to be affected by a proffered program.

"(3) Coverage in any program devised for as many people as possibly can be included.

"(4) Encouragement of the participants in a program which usually means industry and the worker to assume and share together financial responsibility for a program with a minimum State participation.

"Avoidance of Federal or State domination and control of programs and the utilization of the organization and facilities of the institutions most affected by the program.

BENEFITS TO BE INCLUDED

"We have proceeded on the assumption that government encouragement and sympathy for a program need not imply all-out governmental administrative control. With these thoughts in mind I have asked those who have been studying a program of general hospitalization insurance to present an outline of a workable program that you might consider for adoption.

"Such hospitalization should include meals and dietary service, general nursing care, operating room as needed, ordinary medicines and dressings, laboratory examinations, oxygen and serum, physical therapy, maternity care, emergency care and mental and tubercular care. These services could be provided on an employer-employee contributing basis. They can be had through the Blue Cross, or any other authorized insurance company, willing to insure for these minimum benefits and for a stated number of days. It is our belief based upon present studies that this assurance of hospitalization to himself and his dependents could be had for perhaps less than five cents per employed person per day.

"If the State, our voluntary hospitals, the medical profession (and in this respect let me say that the medical profession alone should be the judge of the need of a person for hospitalization) join with labor and with industry in exercising vision, energy and determination to achieve the broad purpose of such a program, and attempt to reach a satisfactory formula for effecting it, we shall eliminate the need or the dangers of a Federal program in this field."

According to a later report of the *Washington News Letter* at the first meeting of the Rhode Island commission named by the Governor, "considerable sentiment in favor of extending the plan to cover the broader field of health insurance was expressed by the doctors and labor leaders of the Council".

President Refers to Medical Care In "Second Bill of Rights"

In his message on January 10 to the second session of Seventy-eighth Congress President Roosevelt said, in part:

"We have come to a clear realization of the fact that true individual freedom cannot exist without economic security and independence. 'Necessitous men are not free men.' People who are hungry and out of a job are the stuff of which dictatorships are made.

"In our day these economic truths have become accepted as self-evident. We have accepted, so to speak, a second Bill of Rights under which a new basis of security and prosperity can be established for all—regardless of station, race, or creed.

"Among these are:

"The right to adequate medical care and the opportunity to achieve and enjoy good health;

"The right to adequate protection from the economic fears of old age, sickness, accident, and unemployment;

"The right to a good education.

"All of these rights spell security. And after this war is won, we must be prepared to move forward, in the implementation of these rights, to new goals of human happiness and well-being.

"I ask the Congress to explore the means for implementing this economic bill of rights—for it is definitely the responsibility of the Congress so to do."

Coming Meetings

Ohio State Medical Association, Columbus, May 2-4.

American Medical Association, Chicago, June 12-16.

Northern Tri-State Medical Association, Toledo, April 11.

Last Call for 1944 Membership Dues!

This Issue of The Journal the Last Which Can Be Sent to Unpaid Members—See Your Local Secretary Immediately

THIS, the March issue of *The Journal*, will be the last issue which will be received by those who have not paid their 1944 Ohio State Medical Association dues, except THOSE IN MILITARY SERVICE WHO ARE CONTINUED ON THE MEMBERSHIP ROSTER THROUGH WAIVER OF ANNUAL DUES. This action is necessitated to comply with the Postal Regulations and the Constitution and By-Laws of the State Association.

TO BE SURE OF RECEIVING *THE JOURNAL* WITHOUT INTERRUPTION, THOSE WHO HAVE NOT PAID THEIR STATE ASSOCIATION DUES SHOULD GET IN TOUCH IMMEDIATELY WITH THE SECRETARY-TREASURER OF THEIR COUNTY MEDICAL SOCIETY WHO HAS THE RESPONSIBILITY OF FORWARDING DUES TO THE HEADQUARTERS OFFICE AT COLUMBUS.

As soon as membership dues are received at the Columbus office, the member's name will be restored to the membership roster and *The Journal* mailing list.

IF YOU HAVE NOT DONE SO, PAY YOUR 1944 DUES IMMEDIATELY TO YOUR LOCAL SECRETARY-TREASURER IN ORDER TO KEEP YOURSELF IN CONTINUOUS GOOD STANDING AS A MEMBER AND TO INSURE RECEIPT OF THE APRIL ISSUE, AND SUBSEQUENT ISSUES, OF *THE JOURNAL*.

Estimate Veterans' Administration Will Need 100,000 Additional Beds

The U. S. Veterans Administration has 66,305 hospital beds in its 93 facilities and is utilizing 2,859 beds in other government and contract hospitals, and this number will be increased to 87,000 under presently approved or contemplated construction programs, according to a recent announcement of Brig. Gen. Frank T. Hines administrator. From Dec. 7, 1941 to Sept. 30, 1943 a total of 26,000 veterans of the present war had been hospitalized by the Veterans Administration. Of that number 17,000 had been discharged as recovered, improved or arrested and 7,800 remained under care on September 30, 1943. Gen. Hines estimates that around 300,000 beds will be needed to enable veterans of World War II to receive hospital and domicilary care to the extent provided veterans of other wars. Although this estimated maximum will not be needed until long after the cessation of the war, it will require the eventual additional construction of not more than 100,000 beds. Present plans of the Veterans Administration call for a total of 100,000 beds, and it is anticipated that about the same number may be obtained from the Army and Navy when these services have completed their medical and surgical treatment of the wounded at the termination of the war.

College of Surgeons To Hold War Session in Cincinnati

Cincinnati has been selected as one of the 22 cities distributed throughout the United States and Canada at which one-day War Sessions will be held by the American College of Surgeons during March and April. The meeting at Cincinnati, to which all physicians in Ohio, Kentucky, Indiana and West Virginia are invited, will be held at the Netherland Plaza Hotel on Wednesday, March 8.

Advancements in military medicine and developments in civilian medical research and practice under the spur of the war emergency will be presented by authorities representing governmental agencies and by civilian physicians and surgeons.

The meeting will open at 8:30 A. M. with the showing of official Army and Navy films on medical and surgical subjects, and continue throughout the day with addresses by representatives of the armed service, U. S. Public Health Service, the Procurement and Assignment Service, and the Office of Civilian Defense.

The concluding session will be a dinner meeting and an open forum with all the participants in the day's program as the panel of experts to lead the discussion. Further information can be obtained by addressing the American College of Surgeons, 40 East Erie St., Chicago.

Ohio's Women's Field Army Against Cancer Needs Aid of Physicians In Enlistment Campaign During April

BY Congressional enactment, April is known as "Cancer Control Month" throughout the United States. It has been similarly designated by Governor Bricker in Ohio. During April the Ohio Division of the Women's Field Army, American Society for the Control of Cancer, will intensify its educational activities in connection with its annual membership campaign.

Annual membership is $1.00 and 75 per cent of funds collected remain in Ohio for the educational program and 25 per cent go to the American Society for the Control of Cancer. In any county which succeeds in enlisting $100, a local project approved by local, state and national committees is established which disburses for local purposes such as hospital equipment, special educational material, etc., the funds remaining after the 25 per cent to the American Society for the Control of Cancer and the 20 per cent to the Ohio Division have been paid.

NEED FOR PROGRAM SHOWN

That there is need in Ohio for this educational program is shown by the accompanying data furnished by the Ohio Department of Health. The data shows the death rate from cancer in this state has increased from 72.88 per 100,000 in 1909 to 138.62 per 100,000 in 1941. While 1942 showed a slight drop, it should be noted that similar pauses in 1929 and 1933 were followed by further increases.

The Ohio Division of the Women's Field Army conducts a year-round educational program through distribution of literature, educational films, speakers, and radio and newspaper publicity.

The success of this program rests in a large measure on the cooperation of the medical profession. It has the approval of the American Medical Association and the American College of Surgeons. Ohio's part in this nation-wide movement was endorsed by The Council of the Ohio State Medical Association, April 27, 1937. Policies of the Women's Field Army are determined by a State Executive Committee whose members are approved by The Council of Ohio State Medical Association before appointment.

PERSONNEL OF COMMITTEE

The 1944 Executive Committee has 14 members, nine of whom are physicians. They are: Dr. Lawrence A. Pomeroy, Cleveland; Dr. Edgar C. Baker, Youngstown; Dr. Farrell T. Gallagher, Lakewood; Dr. J. Henry Lazzari, U. S. Army; Dr. R. H. Markwith, Ohio Director of Health; Dr. Edward J. McCormick, Toledo; Dr. Walter W. McKay, Warren; Dr. Robert A. Stack, Lorain; and Dr. Carl A. Wilzbach, health commissioner of Cincinnati. Other members of the Executive Committee are: Miss Bell Greve, State Commander, Cleveland; Mr. Richard M. Bourne, Treasurer, Cleveland; Mr. H. Austin Hauxhurst, Counsel, Cleveland; Mrs. Marguerite G. Tremaine, Cleveland; and Mrs. Frances S. Wyman, Cincinnati.

The State Commander, Miss Greve, is a well-known welfare worker and a former superintendent of the Division of Charities, Ohio Department of Public Welfare. A state office is maintained at 414 The Arcade, Cleveland 14, Ohio. The Women's Field Army is attempting to complete the organization of a local unit in each county just as soon as possible.

The Women's Field Army is counting heavily on the support of the medical profession. Physicians are being requested to speak on the radio and address public meetings on the value of regular physical examinations, the importance of the recognition of early symptoms of cancer and the necessity of prompt treatment when symptoms of cancer are discovered.

CANCER DEATHS REPORTED TO THE OHIO DEPARTMENT OF HEALTH FOR THE YEARS 1909 THROUGH 1942, INCLUSIVE AND RATE PER 100,000 TOTAL POPULATION

Year	Total Cancer Deaths	Death Rate per 100,000 Total Population
1909	3402	72.88
1910	3620	75.93
1911	3697	75.97
1912	3926	79.06
1913	4054	80.04
1914	4194	81.21
1915	4309	81.86
1916	4691	87.47
1917	4780	87.51
1918	4792	86.17
1919	4891	86.41
1920	5135	89.15
1921	5285	90.37
1922	5552	93.51
1923	5791	96.10
1924	5922	96.85
1925	6120	98.66
1926	6447	102.46
1927	6520	102.18
1928	6884	106.41
1929	6883	104.95
1930	7085	106.59
1931	7101	106.41
1932	7662	114.37
1933	7618	113.27
1934	8043	119.13
1935	8263	121.92
1936	8543	125.57
1937	8603	125.97
1938	8842	128.97
1939	9169	133.24
1940	9446	136.74
1941	9580	138.62
1942	9534	136.80

Names of 30 Ohio Physicians Added to Military Roster During Month; Total in Services is Now 2,748

THE names of 30 Ohio physicians were added to the Ohio State Medical Association Military Roster during the past month, making a total of 2,748 Ohio physicians who are now on active duty with the Army, Navy or other governmental agencies. This total is divided as follows: Army, 2,342; Navy, 338; other services, 68. Those whose names were added to the roster, those promoted, and the tabulation by counties, follows:

NAMES ADDED TO MILITARY ROSTER

Name	City	Rank
Askue, Chester M.	Youngstown	Capt., U.S.A.
Atkinson, William H.	Youngstown	1st Lt., U.S.A.
Baim, Robert R.	Toledo	Capt., U.S.A.
Biedenbender, Harold L.	Cincinnati	1st Lt., U.S.A.
Bonner, John C.	Cincinnati	1st Lt., U.S.A.
Clark, Thomas E.	Columbus	Lt. (j.g.), U.S.N.
Hait, Louis	Lorain	1st Lt., U.S.A.
Hayward, Joseph C.	Columbus	Major, U.S.A.
Jackson, Katherine E.	Cincinnati	Capt., U.S.A.
Kahn, Raymond M.	Dayton	1st Lt., U.S.A.
Kelley, Warren S.	Cleveland	Lt. (j.g.), U.S.N.
King, Clair B.	Canton	Lt. Comdr., U.S.N.
Larsen, Charles	Cleveland	Lt. (j.g.), U.S.N.
Laughbaum, Thurman R.	Galion	P.A.S. (Res.) U.S.P.H.S.
Linn, Robert F.	Lakewood	1st Lt., U.S.A.
Love, Duane D.	Sandusky	1st Lt., U.S.A.
Marshall, Robert L.	Columbus	1st Lt., U.S.A.
Nozik, Benjamin	Cleveland	Capt., U.S.A.
Piercy, Robert L.	Youngstown	1st Lt., U.S.A.
Preston, Burman H.	Cincinnati	Capt., U.S.A.
Richards, Edwin D.	Cleveland	Lt., U.S.N.
Rosewater, Ralph S.	Lakewood	1st. Lt., U.S.A.
Schuster, George	Toledo	Lt. (j.g.), U.S.N.
Skaggs, Marshall L.	Cincinnati	1st Lt., U.S.A.
Stilwill, Maurice E.	Massillon	1st Lt., U.S.A.
Taketa, Tom	Cleveland	1st Lt., U.S.A.
Terrell, Virgil E.	Lakewood	1st Lt., U.S.A.
Tobin, John	Cleveland	Lt. (j.g.), U.S.N.
Wendorf, Harris S.	Marion	Capt., U.S.A.
Wigser, Abraham M.	Cincinnati	Capt., U.S.A.

WIN PROMOTIONS

Name	City	Rank
Adelman, Jack A.	Columbus	Major, U.S.A.
Amato, N. G.	Cincinnati	Capt., U.S.A.
Apanasewicz, Leo E.	Cleveland	Capt., U.S.A.
Arn, Roy D.	Dayton	Lt. Col., U.S.A.
Ball, O. D.	New Lexington	Major, U.S.A.
Baumgartner, Myron R.	Bolivar	Capt., U.S.A.
Beck, Harry W.	Canton	Major, U.S.A.
Beckerman, Samuel	Cleveland	Capt., U.S.A.
Betts, Thomas F.	Findlay	Capt., U.S.A.
Boettner, John F.	Cleveland	Major, U.S.A.
Bogue, Chas. A.	Warren	Capt., U.S.A.
Bonnell, G. H., Jr.	Worthington	Major, U.S.A.
Brown, Harold E.	Columbus	Capt., U.S.A.
Brumm, Lewis P.	Cincinnati	Capt., U.S.A.
Burgin, Bernard	Cincinnati	Capt., U.S.A.
Caravona, D. P.	Cleveland	Capt., U.S.A.
Carter, B. N.	Cincinnati	Col., U.S.A.
Castle, Edward B.	Shaker Heights	Major, U.S.A.
Consolo, Charles W.	Tiffin	Capt., U.S.A.
Crist, J. O.	Centerburg	Lt. Col., U.S.A.
Dobkin, J. J.	Toledo	Capt., U.S.A.
Dornheggen, John H.	Cincinnati	Capt., U.S.A.
Drown, W. G.	Warren	Major, U.S.A.
Dummer, Clyde M.	Cincinnati	Major, U.S.A.
Egeberg, Roger O.	Cleveland	Lt. Col., U.S.A.
Everett, Clyde W.	Cleveland	Lt. Col., U.S.A.
Feldman, Stanley L.	Cleveland	Capt., U.S.A.
Fishman, David	Cleveland	Capt., U.S.A.
Friedman, D. L.	Toledo	Capt., U.S.A.
Geiger, Franklin R.	Cincinnati	Capt., U.S.A.
Glenn, Paul M.	Cleveland	Major, U.S.A.
Goldberg, Lawrence C.	Cincinnati	Capt. U.S.A.
Hamsher, John F.	St. Paris	Lt. Col., U.S.A.
Harris, Samuel F.	Cincinnati	Capt., U.S.A.
Herman, Wm. W.	Cleveland	Capt., U.S.A.
Kechele, Oliver J.	Berea	Major, U.S.A.
Lamkin, Glenn S.	Sardinia	Capt., U.S.A.
Leffler, Paul B.	Toledo	Major, U.S.A.
Leichliter, John W.	Cincinnati	Lt. Col., U.S.A.
Levin, David K.	Toledo	Capt., U.S.A.
Lewis, David R.	Grove City	Capt. U.S.A.
Malmud, M. M.	Sharon Center	Capt., U.S.A.
Marcus, L. L.	Toledo	Major, U.S.A.
McCready, Robert G.	Akron	Capt., U.S.A.
Merrill, R. E.	Delta	Capt., U.S.A.
Meyers, J. S.	Versailles	Capt., U.S.A.
Miller, Donald A.	Youngstown	Major, U.S.A.
Noll, John, Jr.	Youngstown	Lt. Col., U.S.A.
Nulsen, Ray O.	Cincinnati	Capt., U.S.A.
Osherwitz, M. S.	Cincinnati	Capt., U.S.A.
Payne, Leonidas W.	Willoughby	Major, U.S.A.
Petcoff, John E.	Toledo	Capt., U.S.A.
Price, Pliny A.	Toledo	Capt., U.S.A.
Prochaska, Chas. J.	South Euclid	Major, U.S.A.
Pulford, Dayton T.	Toledo	Major, U.S.A.
Sadugor, Marvin G.	Cleveland	Major, U.S.A.
Sauer, Richard T.	Dayton	Major, U.S.A.
Sawyer, Warren C.	Marion	Major, U.S.A.
Shoene, Robert H.	Columbus	Capt., U.S.A.
Seesholtz, John R.	Toledo	Capt., U.S.A.
Sherman, M. L.	Dayton	Major, U.S.A.
Smith, Paul W.	Lorain	Capt., U.S.A.
Solt, R. L.	Bucyrus	Comdr., U.S.N.
Tillman, Norbert A.	Lorain	Lt. Col., U.S.A.
Vail, Derrick T.	Cincinnati	Col., U.S.A.
Weil, Alven M.	Akron	Major, U.S.A.
Williams, J. R.	Eaton	Capt., U.S.A.
Wilson, Sloan J.	Columbus	Lt. Col., U.S.A.

TABULATION BY COUNTIES

Adams	2	Guernsey	6	Muskingum	9
Allen	38	Hamilton	416	Noble	1
Ashland	10	Hancock	12	Ottawa	9
Ashtabula	17	Hardin	7	Paulding	2
Athens	12	Harrison	4	Perry	4
Auglaize	6	Henry	2	Pickaway	5
Belmont	12	Highland	8	Pike	2
Brown	4	Hocking	4	Portage	2
Butler	29	Holmes	2	Preble	7
Carroll	1	Huron	15	Putnam	6
Champaign	8	Jackson	1	Richland	38
Clark	31	Jefferson	30	Ross	24
Clermont	9	Knox	11	Sandusky	11
Clinton	7	Lake	18	Scioto	19
Columbiana	11	Lawrence	7	Seneca	12
Coshocton	4	Licking	17	Shelby	7
Crawford	10	Logan	8	Stark	95
Cuyahoga	674	Lorain	37	Summit	147
Darke	6	Lucas	154	Trumbull	28
Defiance	4	Madison	6	Tuscarawas	19
Delaware	7	Mahoning	114	Union	2
Erie	10	Marion	16	Van Wert	9
Fairfield	9	Medina	13	Vinton	2
Fayette	2	Meigs	3	Warren	4
Franklin	223	Mercer	6	Washington	7
Fulton	6	Miami	13	Wayne	13
Gallia	4	Monroe	1	Williams	8
Geauga	4	Montgomery	135	Wood	17
Greene	7	Morgan	3	Wyandot	3
Total					2748

Crippled Children Seal Sale

The eleventh annual sale of Easter seals for crippled children, sponsored by the National Society for Crippled Children and its affiliated organizations, will be conducted this year from March 9 to April 9. Easter seals cost a penny each or $1.00 per sheet of 100.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

IF IMPROVEMENT IS NEEDED, LET'S DO THE JOB THE RIGHT WAY

In the January 29, 1944, issue of *The Journal of the American Medical Association*, page 305, there appeared a statement over the signatures of the members of the Board of Trustees of the American Medical Association, entitled, "A Message to the Members of the American Medical Association".

We are in agreement with many of the statements made by the Board. However, we must admit that the general tone of the message was a strained attempt to give the impression that everything is rosy and that the goose hangs high. With some of the views expressed, we sincerely and heartily disagree. This does not necessarily prove that we are right and the Board wrong.

The American Medical Association, as an organization, is not perfect. What organization is? The Ohio State Medical Association is not perfect; neither is any county medical society. This journal is not perfect. An organization is simply the sum total of its members. Who would be bold enough to even imply that all the members of the A.M.A. are infallible. Therefore, **Point No. 1 is that we cannot expect perfection on the part of the A.M.A. but even the most loyal member has a right to expect improvement when improvement is indicated.**

Be that as it may, when an organization—any organization—commits sins of omission or commission (all will because they are composed of human beings), that is not an excuse for some of its members to become rebellious to the point of propagandizing for rump sessions or an independent organization. The Bull Moosers tried that. What happened is well known. That is a fine way to destroy democratic processes and to supplant them with fascism.

Any time a group of persons, no matter how sincere or well meaning, decide that they need a new organization because they are dissatisfied with the organization to which they belong and the contemplated activities of the new organization would merely duplicate the work which the original organization is, should or can be doing, they simply fool themselves. They dilute their strength and potentialities. They imply that there is strength in multiplicity of organizations. This is bad logic. They are guilty of poor planning and strategy. **Point No. 2: There is more strength in one, well-organized, alert organization than in dozens of independent groups imbued with a desire to perform some special "mission".**

The American Medical Association may not be doing the kind of a job which the majority of its members believe should be done. No poll has been taken, so there are no statistics to prove this. But, if that is true, the sensible approach to the question would be for the majority of members to take steps to see that corrective measures are initiated. The insane approach would be to do something which might ultimately result in the destruction of the A.M.A.—at least a split which would damage its usefulness. Even if it has flaws, the A.M.A. is a great and distinguished organization. Based on its record alone it is certainly worth preserving. **Point No. 3: Whatever action is taken should have one objective, namely, to strengthen and to improve the A.M.A. and engender greater loyalty for it among the medical profession generally.**

Those who may be dissatisfied with the way the American Medical Association is being administered have a right to their opinion. Some of their criticism may be justifiable; some of it may not. But, we are convinced of one thing, namely: The tactics being pursued by both critics of the A.M.A. and by ardent supporters of the A.M.A. are fundamentally wrong. The A.M.A. is not as bad as some of its critics would have us believe. By the same token, the A.M.A. is not as perfect as some claim it is and is not putting as much on the ball as it should. An arbitrary attitude by both schools of thought will not lead to improvement, merely create more confusion. **Point No. 4: If improvements are needed in medical organization—and they are needed—the beginning must be made at the grass roots. Organization of another society and habitual carping and complaining will not do the job. Neither will a defensive attitude and one of complacency on the part of those directing the affairs of the A.M.A.**

Improvements in the A.M.A. must start with improvements in each county medical society and in each state medical society. Some of those who complain that the A.M.A. doesn't do this or that would not take an important assignment in their own county medical society if it were to be offered on a silver platter, let alone assume any responsibility in state association or A.M.A. activities. How many of those who find fault with *The Journal of the A.M.A.* or *The Ohio State Medical Journal* would contribute an article even if invited to do so? How many members showed up for the election of officers at your

county society annual meeting? Were you there? Do you know who is Councilor of your district; who are serving on important committees of the State Association? Is your society careful in whom it selects to represent it in the House of Delegates of the State Association where the State Association officers are elected and A.M.A. delegates selected?

This leads up to **Point No. 5, namely: If all county societies are alert and aggressive, each state society is bound to be a better organization and if each state society is on its toes, this will be reflected in the House of Delegates of the A.M.A., the governing body of the national organization.** The administrative policies of the A.M.A. are laid down by the House of Delegates. If they are in need of modification to comply with the wishes of the majority of the membership, it is the responsibility of the membership to see that representatives who will comply with their wishes are seated in the House of Delegates.

Point No. 6 follows in logical sequence: The members of the A.M.A. would do well to remember that they in the final analysis are the American Medical Association. It is going to be exactly what the majority of the members make it or want it to be, speaking through carefully selected representatives who will be responsive to the desires of those who elected them to office. Affirmative, constructive action will produce improvements; criticism and complacency or the formation of another organization will not.

As the Board of Trustees of the A.M.A. has said, this is a period of stresses and confusion—often muddled thinking. It is the time for the preservation of what is good; elimination of flaws; initiation of improvements from bottom to top, if indicated. But, the job must be done through sane, orderly processes. Medical organization always has, and always will, change with the times. Disciples of the status quo must realize this. If this is the time for revamping of views and methods, let there be action but constructive action; action based on clear thinking; action within the present democratic structure of organized medicine.

DR. SEILER TYPIFIED THE REAL STRENGTH OF THE PROFESSION

The people of Piketon will miss Dr. I. P. Seiler, who died recently following an extended illness. He will be missed by his host of colleagues, friends and acquaintances throughout the state—acquired during 20 years as a member of The Council of the Ohio State Medical Association prior to 1942 when he retired from The Council.

Dr. Seiler served the people of his community faithfully and efficiently not only as a physician but also as a public official in the capacity of mayor of the town of Piketon and as a member of the local board of education.

As a member of The Council of the State As-

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sociation he served his profession diligently, taking a major part in many of the activities which have made the State Association an agency of real value to the profession, individually and collectively.

Dr. Seiler and what he did and stood for typify the real strength of the medical profession. There are others like him in various parts of Ohio—those who have not taken the prominent part which he took in organization affairs but who nonetheless measure up to the sentiments expressed editorially by the *Chillicothe Gazette* following Dr. Seiler's death:

"Those who may say there is no future for the rural practitioner overlook such men as Dr. Seiler who have found rich rewards for their industry and professional skill in the friendly, appreciative rural areas."

SOME REACTIONS FROM OHIO DOCTORS IN THE SERVICES

Each 1944 State Association membership card mailed to Ohio physicians serving with the armed forces and government services was accompanied by a letter asking them for news about themselves and their colleagues and assuring them that those at home "are going to try to do as good a job back home as you are doing at the front".

Hundreds of responses to that communication have been received at the State Headquarters Office. An analysis of these replies, which presumably are a good cross section of the attitude and thinking of the men in the service, produces enlightening answers to some of the questions which are in the minds of those at home.

Are most of those in the services interested in retaining their affiliation with organized medicine and in seeing it maintained? **Emphatically yes!**

Are most of those in the services expecting those at home to do everything possible to prevent the inauguration of programs which would destroy private enterprise in the practice of medicine? **Emphatically yes!**

Are most of those in the services converted to the theory that regimented medical services as practiced in the armed forces, through necessity, are an adequate substitute for medical services provided on a private patient-physician relationship? **Emphatically no!**

Do many of those in the services feel that the medical profession after the war will be confronted with increasing responsibilities, especially those of making readjustments in past and present methods of providing medical services, but adjustments which will maintain the standards of medical care and provide for supervision and guidance by the medical profession? **Yes!**

Are many of those in the services anticipating that adequate arrangements will be made to provide them with opportunities for postgraduate training at the conclusion of the war? **Yes!**

Are most of those in the services appreciative of the special efforts being made by physicians at home to "keep things on an even keel" and to "fill the gaps on the home front"? **Yes!**

Are all of those in the services eager to hear from their medical societies and from their colleagues at home? **Yes!**

Do most of those in the services imply that they expect to return to their former locations and practices at the end of the war? **Yes!**

Are most of those in the services accepting the lot which fate has handed them in a grin-and-bear-it spirit, without feeling sorry for themselves, without resentment? **Yes!**

Do those in the services anticipate an early end of hostilities? **No!**

There are other points which could be listed but these samplings are sufficient to challenge the attention of those back home and to stimulate increased activity.

One letter received from one of Ohio's better known physicians, now a Colonel, M.C., contains so much food for thought that it is worthy of special attention. Here is what this medical officer wrote:

"Thank you and the Directors of the Association very much for your action with regard to dues for 1944. I think this is a very proper action.

"All the men in Service wish to continue their relations with their Medical Societies and yet, under the present circumstances, it is impossible to pay dues.

"When we are going to be back in civilian life is a question which is very difficult to answer but our civilian connections are very dear to every one of us, and we hope that the medical situation is not going to be too greatly disturbed when we do return.

"However, there are many elements of the medical problem which will face us at the termination of the war that I do not believe civilian doctors completely visualize. There is going to be a large problem in the care of the veterans of this war. At the present time the Veterans Bureau has close to 90,000 veterans of the last war in its facilities. The number that can be expected to be added to that because of this war will be at least three times as many more, so that it is quite possible that all the Government

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hospitals which are at present being operated under different auspices will have to be continued for the care of this large number of veterans.

"Under any type of termination of this war, there is going to be a continuation of the Army considerably larger than any that we have previously maintained which will necessitate additional medical officers. Add to this the problems of sanitation that are going to develop all over the world in territories that have been occupied or devastated which will be burdened on some agency like UNRRA, which means very largely a burden upon the United States which we must assume even though we do not assume the administration of these areas. If we do not assume certain sanitary responsibilities it will backfire upon the rest of the world in epidemics and the transmission of various situations that ought to be quarantined—all of which will require American medical personnel.

"It is, therefore, apparent that a considerable portion of the doctors who have gone into Service will continue to be in Service even after the cessation of hostilities and that medical difficulties at home will have to be more than a matter of a passing emergency.

"I have no wish to be pessimistic in this matter but since I am in a position where I see many medical officers leaving the country to go overseas and having talked with many of these men who see the future more or less clearly, I think that it is well to bring the matter to the attention of those of our profession who are seeing it purely from a civilian angle."

RIGHT AND WRONG WAYS OF ADVISING CONGRESSMEN

In all probability every physician in Ohio at some time or another has written to his Congressman or his state representative or state senator about pending legislation. Wonder if you've ever stopped to think about the reaction which your letter created?

Writing to the secretary of the Public Health League of California, Congressman George E. Outland of the 11th California District expressed himself on certain medical and health proposals pending in the Congress and then offered some advice which each physician would do well to remember the next time he writes his national or state legislator.

This excerpt from Congressman Outland's letter, published in the *San Diego County Medical Society Bulletin*, is not only timely but practical:

"Another point which I mentioned in connection with this whole matter has been the type of letter written to my office concerning this particular bill. I welcome communications on this and all other subjects, but I hope that such communications will be helpful and temperate, not simply emotional and intemperate. For example, when a doctor in California writes me (and I here quote verbatim) 'I am violently opposed to this bill; please vote accordingly,' he scarcely is accomplishing his objective!! Letters which are violently partisan in nature or which damn Roosevelt or which refer to any change in the status quo as 'communism' show not only bad judgment but poor taste. On the other hand, some of the most thoughtful letters I have ever received in Congress have come from physicians and nurses who have objectively and calmly pointed out what they believe to be real dangers in the proposed bill. Such letters are doubly welcome, since they do shed additional light and not heat on a matter that is arousing such intense feeling."

HOW DOCTOR CAN HELP ALLEVIATE THE NURSE SHORTAGE PROBLEM

Most hospitals and communities are confronted with a shortage of nurses, meaning that the services of nurses available for civilian practice must be used to the best advantage.

The public is being requested to cooperate. Physicians also can be of material assistance.

Recently the Cincinnati Academy of Medicine, the Cincinnati Health Department and the Hamilton County Health Department issued a joint bulletin on this question. The following suggestions as to how physicians can help were listed and they can, and should, be followed by physicians in all communities:

1. Recommend special nurses for service in homes only when it is essential.
2. Use the hourly service of the Visiting Nurse Association instead of full-time special nurses when possible.
3. For your hospital patients, advise with the nursing office of the hospital so that together you can decide which patients should have priority and in some cases, perhaps, arrange for one special nurse to service more than one patient.

LESSONS LEARNED FROM INDUSTRIAL HEALTH CONFERENCES

In general the series of Industrial Health Conferences held in Toledo, Cleveland, Columbus and Cincinnati the second week in February, under the auspices of the Ohio State Medical Association and the Ohio Department of Health, were extremely successful. Although the attendance was not as large at any one meeting as the programs merited, those who did attend obviously were those who will take the leadership in local industrial health activities. The addresses by the guest speakers were timely and full of meat; their suggestions practical. The local speakers showed that they understand the importance of a workable industrial health program and what it can accomplish.

One point which all of the speakers stressed again and again was that every physician in the final analysis is an industrial physician, using the term in its broadest sense.

Those who may see only an occasional workman injured in the course of employment must not lose sight of the fact that non-industrial disabilities and illnesses cause more absenteeism than those resulting from occupational hazards.

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the family physician, or specialist, are important factors in keeping the working man on the job. Counsel by the family physician, or specialist, frequently will alleviate mental and emotional conditions which cause lost time or make the worker a potential hazard to himself while on the job. Cooperation between the attending physician and the employer often will bring about re-assignment of the worker to the kind of work for which he is better fitted, physically and emotionally.

Another point which was emphasized was that every physician should become more familiar with the working conditions of his patients and the potential health hazards confronting them. In other words, physicians should visit places of employment so they will have a basic knowledge of factors which may directly or indirectly have a bearing on the health of those employed and, in doing so, improve their ability to advise not only employes but employers, as well.

The conferences were a step forward in the state-wide industrial health program. The next big step is to retain the momentum which the conferences created. That can be done by greater activity by all County Society industrial health committees. The pamphlet issued some months ago by the Committee on Industrial Health of the State Association offers some good suggestions for local activity. It is hoped that all the local committees will initiate something concrete immediately.

TRIALS AND TRIBULATIONS OF THE WAR-TIME G.P.

The Ohio physician in an extremely rural area who inserted the following advertisement in the county seat newspaper quite obviously is not a student of diplomacy but we'll lay a wager that he got results, and, seriously speaking, there are still too many folks who have to be hit with a brickbat to make them realize that the war is still going on and that a doctor's services, like a lot of other things, have to be rationed, with the actually ill getting priority:

"To My Patients:

"During this emergency time and circumstances make definite rules necessary.

"If I am to continue to give you all the service within my power, you must give me and my nurse a chance to get enough food and rest to keep on the job. When nights and Sundays are used like the regular working day, no human being can stand it.

"Lately we had 37 patients on one Sunday (only four of them emergency cases), and in one week 128 calls after midnight (all of these except three baby cases could have properly waited till the next day). If such unnecessary calls are not stopped, we will give no service out of hours, as is done in other towns. To call a doctor out on Sunday or at night for nothing, is like having a grocery open at night because you neglected to get your groceries the day before. Almost all of the night and Sunday cases have been ill a few days or a few weeks.

"Now it is up to you. Call the office only, and after 10:00 A.M. or before 9:00 P.M., and don't leave them over for nights and Sundays."

LINCOLN'S DEFINITION TOO GOOD TO BE FORGOTTEN

Have you noticed how often Lincoln is quoted these days by those who feel that it is high time for Uncle Sam to take an inventory?

We ran across this one recently. When Lincoln was asked to define democracy he wrote: "As I would not be a slave, so I would not be a master. This expresses my idea of democracy. Whatever differs from this, to the extent of the difference, is no democracy".

Senator Wagner, *P.M.*, members of the deceased National Resources Planning Board, members of the Social Security Board, and those who think bureaucracy is an adequate substitute for free enterprise, please copy!

FACTS, FANCIES AND PHILOSOPHY

Congressional Record: "Senator Overton. It looks like nearly every bill that comes up is trying to socialize medicine one way or another. It is sticking its nose in here and sticking its nose in there."

* * *

Report of Social Security Board: "Within localities, moreover, sickness varies according to income level. The chance for health, and even for survival, is least among the poor." (The Wagner Bill does not contemplate raising the income level.—Editor's Note.)

* * *

Columbus Dispatch: "Dr. A. R. Mangus, rural sociologist, urged Ohio rural residents to 'do something about it' by discussing group health plans and studying the merits of tax-supported medical and hospital service." (All county medical societies please note.—Editor's Note.)

* * *

The Ohio Cooperator: "Every local consumer cooperative in the United States should make plans now to open a medical care department as soon as the war is over. This is urged by Dr. James T. Warbasse, president emeritus of The Cooperative League of the United States."

* * *

New York Times: "Mr. Williams (Claude A. Williams, executive director, Texas Unemployment Compensation Commission) then asked, 'What do you think will happen if a man can make more by being idle than he can by working? You can bet he will be idle. The bill (Wagner Bill) puts a premium on being idle.'"

* * *

Eric A. Johnston, president, United States Chamber of Commerce: "Our system of social

In the "Chronic Fatigue" of Mild Depression



After employing Benzedrine Sulfate therapy in a series of 40 patients diagnosed as suffering from nervous exhaustion, Nathanson concludes:

"In approximately 80 percent of the patients there was a marked amelioration of this symptom (fatigue). Many of the patients had complained of fatigue for long periods and had tried various types of treatment without benefit . . .

"A sense of increased energy and capacity for work was noted in more than half of the cases. In addition a feeling of exhilaration and sense of well being was a consistent effect . . . Many patients volunteered that there had been a definite increase in mental activity and efficiency." Nathanson, M. H.—J. A. M. A., 108:528, 1937.

Benzedrine Sulfate Tablets

Brand of racemic amphetamine sulfate

Benzedrine Sulfate is primarily useful in depressions characterized by apathy and psychomotor retardation, but is contraindicated in patients manifesting anxiety, hyperexcitability, or restlessness.

The use of Benzedrine Sulfate by normals should not be permitted; it should always be administered under the careful supervision of a physician; and depressive psychopathic cases should be institutionalized.

In treating depressed patients with Benzedrine Sulfate, the physician should bear in mind that any drug which produces pleasant or euphoric effects may prove to be habit forming—especially in unstable or neurotic individuals.

SMITH, KLINE & FRENCH LABORATORIES
PHILADELPHIA, PA.

security should be so designed and, if you will, so propagandized, that it will encourage individual thrift and so that it will promote voluntary group action . . . administration must be close to the people affected . . . the content of these programs should be determined largely at the local level."

* * *

Sermon by Rev. Arnold Crompton, First Unitarian Church, Erie, Pennsylvania: "These programs proceed on the assumption that physicians and surgeons are evil creatures, enemies of the people, who need to be under strict governmental supervision. They assume that all medical men want are high fees. They assume that in order that people may receive good treatment, doctors must be guarded like common criminals. Yes, there are doctors whose ethical practices are not above reproach. There are doctors who are money-mad. And, there are doctors who are reactionaries on social issues and who band themselves together to defeat progress. Is this sufficient justification for the state to assume control of the entire profession? It is? Then put every other trade and profession under the same control, for the same evils are manifested in them. But don't forget what happens in the process. You replace democracy with its conception of the dignity of man, with a state-dictatorship based on the bestiality of man. And the freedom so hard fought for at Guadalcanal, Attu, and Africa is gone as though those victories had been defeats."

P.M. DOESN'T LIKE US AND OUR LITTLE PAMPHLET

In a recent issue, *P.M.*, the New York City newspaper which has appointed itself as the official reformer of about everything, undertakes to "expose" the campaign of organized medicine in opposition to the Wagner-Murray-Dingell Bill.

Among other illustrations, it reproduces the cover page of the pamphlet, "No! The Wagner Bill Is Not the Answer!", produced and distributed by the Ohio State Medical Association "by the tens of thousands", so *P.M.* states, intending to prove, we suppose, that the State Association is guilty of maim, assault and battery, horse stealing—or something.

In our opinion, the State Association is entitled to a bow. Anyone who can penetrate the hide of *P.M.* is. The pamphlet must be better than we had even judged it to be. Incidentally, *P.M.* should have said "hundreds of thousands" as the pamphlets are still rolling off the presses.

Better get another supply! We don't want to disappoint *P.M.* which intimates that the good work which the medical profession and allied groups in all states are doing has the Wagner Bill on the ropes.

Program for Northern Tri-State Meeting At Toledo on April 11

The Seventy-First Annual Meeting of the Northern Tri-State Medical Association, composed of physicians of Ohio, Indiana and Michigan, will be held Tuesday, April 11, at the Commodore Perry Hotel, Toledo.

Arrangements for the meeting were made by the following officers and councilors: Dr. E. Benjamin Gillette, Toledo, president; Dr. Howard H. Cummings, Ann Arbor, vice-president; Dr. F. R. Nicholas Carter, South Bend, vice-president; Dr. O. P. Klotz, Findlay, secretary; Dr. Frederick F. Yonkman, Detroit, treasurer; Dr. G. O. Larson, LaPorte, Ind., Dr. D. F. Cameron, Ft. Wayne, Dr. G. E. Jones, Lima, Dr. John Stifel, Toledo, Dr. H. B. Randall, Flint, and Dr. W. H. Marshall, Flint, councilors.

The program for the April 11 meeting at Toledo follows:

8:00 to 8:45 A.M.—Registration.

8:45 to 9:00 A.M.—Address of Welcome, Dr. Paul Holmes, president, Toledo Academy of Medicine.

9:00 to 9:45 A.M.—"Chemotherapy", Dr. Gordon B. Myers, professor of medicine, Wayne University College of Medicine.

9:45 to 10:30 A.M.—"Post War Medical Problems Relative to Tropical Diseases", Dr. Robert A. Hettig, instructor in internal medicine, University Hospital, Ann Arbor.

10:30 to 11:45 A.M.—"The Management of the Asthmatic": Roundtable discussion by Dr. Karl D. Figley, Toledo; Dr. Milton B. Cohen, Cleveland; and Dr. Stanley W. Insley, assistant professor of medicine, Wayne University College of Medicine.

11:45 to 12:00 Noon—"Caudal Anesthesia", Dr. Henry Close Hesseltine, associate professor of obstetrics and gynecology, University of Chicago Lying-In Hospital.

12:00 Noon to 1:15 P.M.—Luncheon, Ball Room.

1:15 to 2:00 P.M.—"Diagnosis and Treatment of Medical Shock", Dr. M. A. Blankenhorn, director, Department of Internal Medicine, University of Cincinnati College of Medicine.

2:00 to 2:45 P.M.—"The Role of Biochemistry in the Etiology and Treatment of Cardio Vascular Renal Disease", Dr. Nathan S. Davis, assistant professor of medicine, Northwestern University Medical School.

2:45 to 3:30 P.M.—"Diagnosis and Treatment of Ruptured Intervertebral Discs", Dr. Walter E. Dandy, professor of neurological surgery, Johns Hopkins Hospital, Baltimore.

3:30 to 3:45 P.M.—Business session.

3:45 to 4:30 P.M.—"Penicillin" (slides), Dr. Wallace E. Herrell, assistant professor of medicine, Mayo Foundation Graduate School, University of Minnesota.



THE "RAMSES"* Diaphragm Introducer, designed after consultation with gynecologists, engages the rim of the "RAMSES" Flexible Cushioned Diaphragm at two points, shaping it into an elongated oval, thus enabling it to pass readily into the vagina. By providing complete control over the direction of travel, the "RAMSES" Diaphragm Introducer assures proper and accurate placement of the diaphragm.

1. The wide, blunt tip of the "RAMSES" Diaphragm Introducer is designed to prevent even the remote chance of accidental penetration of the uterus during insertion of the diaphragm.

2. Made of easily cleansed plastic, the "RAMSES" Diaphragm Introducer has no minute crevices to harbour bacterial growth—no sharp projections to cause possible vaginal injury.

3. The broad, rounded hooked end of the "RAMSES" Diaphragm Introducer—used for diaphragm removal—guards against possible entry into the urethra.

Your patients obtain the "RAMSES" Diaphragm Introducer when you specify the "RAMSES" Physician's Prescription Packet No. 501, which also contains: A "RAMSES" Flexible Cushioned Diaphragm of the prescribed size. A large size tube of "RAMSES" Vaginal Jelly.

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DIAPHRAGM INTRODUCER



WAR NOTES

Col. Herbert B. Wright, Cleveland, was elected president of the American Medical Society of the European Theater of Operations, at a meeting in England on January 20. The medical society is composed of U.S. Army medical officers stationed in the United Kingdom. It has smaller branches in the various sections of England. Regular meetings are held in an effort to bring current scientific advances before the medical officers so that their care of the sick and wounded U.S. soldiers will include the very latest methods.

Col. Wright, formerly director of surgery at St. Vincent's Charity Hospital and director of urology at Deaconess Hospital, was recently promoted to his present rank. He is serving on the staff of the highest American Air Force echelon in Europe and reports that the wounded American soldier is receiving the most skilled surgical care, and that co-ordination between the medical officers of the Air Force and the S.O.S. hospitals has been excellent. Col. Wright is attached to the Office of the Surgeon, Hdqrs., U.S. Strategic Air Forces in Europe, APO 633, New York.

* * *

Congratulations to Capt. and Mrs. George O. Thompson, formerly of Alliance, on the arrival of a daughter, out in California, where Capt. Thompson is chief of the medical service at the San Bernardino AAF Station Hospital! And our thanks to one of his Ohio colleagues also on duty at San Bernardino, Capt. J. L. Jones, Medina, for sending us this clever birth announcement:

HEADQUARTERS
COMMUNITY HOSPITAL
REDLANDS, CALIFORNIA

Daily Bulletin No. 29 — 29 January, 1944.

SUBJECT: Arrival of Additional Personnel.
TO: All Civilian and Military Personnel.

1. In compliance with S. O. No. 4, Headquarters, Thompson Residence, 1239 Esperanza Ave., San Bernardino, California, dated 21 April, 1943, Pvt. Penelope Ann Thompson, WAC, weighing 6 lbs. 12 oz., reported for active duty this station 0909m 29 Jan. 1944. The usual nine months delay enroute was authorized.

2. Ten days from this date Pvt. Thompson, Penelope Ann. will be transferred to the Thompson residence in San Bernardino, California, for quarters, rations and special training.

By Order of Capt. George O. Thompson, M.C.
Chief of Finance Division

Gwendoline E. Thompson
Chief of Procurement Division
and Mess Officer.

* * *

Three full gold stripes now adorn the sleeve of Comdr. Robert L. Solt, Bucyrus, who was recently promoted while on duty as chief medical officer of a warship in foreign waters.

Members of the State Headquarters Staff have had a real lift from the hundreds of appreciative letters received from State Association members in the services, acknowledging receipt of their 1944 membership cards. Keep us posted promptly of your change of address—and send us a War Note now and then!

Major Gordon G. Nelson, Youngstown, reports from sunny Italy that he now has a more comfortable bed to sleep on than he had in North Africa—a place which he didn't particularly care about "with its ants, mosquitos, scorpions and dirty Arabs".

* * *

Lt. Daniel S. Bunner, Columbus, is now at Portsmouth, Va., awaiting orders after several months at sea. Lt. Bunner participated in the invasion at Salerno.

* * *

To the Ohio contingent in Australia should be added the name of Lt. (j.g.) Howard F. Kuhn, USN Base Hospital No. 10, Navy 135, San Francisco.

* * *

Capt. Thomas F. Betts, Findlay, with the 909th Field Artillery Bn., Camp Claiborne, La., recently returned from "a pretty rugged maneuver". Now you know, Captain, how your brother Jack feels after a session of the Ohio General Assembly in which he has served for several sessions.

* * *

Lt. F. P. Baurichter, Cincinnati, is in the Medical Department of the U. S. Marine Corps Air Station, Cherry Point, N. C., which is also the location of Lt. Comdr. Harve M. Clodfelter, Columbus, former Councilor of the 10th District, Ohio State Medical Association.

* * *

Major H. M. Amstutz, Lancaster, is in England with the 97th Evacuation Hospital, APO 9130, New York.

* * *

Lt. Col. Norbert A. Tillman, Lorain, is the Post Medical Inspector in Charge of Sanitation at Fort Knox, and is assigned to the Camp Surgeon's office at that station. He was recently promoted to his present rank. Major Morris Tillman and Flight Surgeon Paul F. Tillman,

No Appreciable Rise in Blood Pressure with

PITOCIN

● A sterile, aqueous solution of the oxytocic principle of the posterior pituitary with practically none of the pressor principle . . . a superior product for all cases in which stimulation of the uterine musculature during labor is indicated. PITOCIN* is also indicated for the prevention of postpartum hemorrhage, and is *especially desirable* in those cases in which a rise in blood pressure is contraindicated. ☆ The low protein content and freedom from impurities minimize the incidence of reactions. Meticulous standardization and marked stability assure uniformity of action. ☆ Pitocin has justly earned an important place in delivery rooms and obstetrical kits the world over.

Pitocin (alpha-hypophamine) is available from your pharmacy or hospital dispensary in ampoules of 0.5 cc. and 1 cc., in boxes of 6, 25, and 100.



ARMY E NAVY

*Trade-mark Reg. U. S. Pat. Off.

Parke, Davis & Company, Detroit, Michigan

brothers of Col. Tillman, have also answered the call to service. Major Tillman is in the Army Air Corps at West Palm Beach, Fla., and Flight Surgeon Tillman, following a year of active duty in North Africa, has been retired.

* * *

Commended by the War Department for gallantry in action in the vicinity of Salerno between Sept. 12 and 21, 1943, Capt. Warren C. Sawyer, Marion, was recently promoted to the rank of Major. The official commendation reads:

"He was a member of advance headquarters (blank) fighter wing. During the first days, due to the narrowness of the bridgehead, it was necessary to set up operations far in advance of our own artillery and within range of all calibers of enemy artillery.

"During the almost constant shelling which caused much loss of personnel and equipment, Capt. Sawyer took care of the wounded and performed his many duties without thought of self.

"His cheerful acceptance of danger and great devotion to duty were an inspiration and a comfort to those about him."

* * *

The War Department announced recently that certain army camps which have been vacated by troops sent overseas will be turned over to the Veterans' Bureau for use as Veterans' hospitals.

Formerly at the Army Medical Center, Washington, D.C., Capt. Willard B. Andrus, Columbus, is now attached to the 251st Station Hospital, APO 9415, San Francisco.

* * *

Lt. Col. Roy D. Arn, Dayton, is chief of the surgical staff of a station hospital in New Guinea.

* * *

Another Ohio physician in New Guinea is Capt. W. J. Franke, Akron, who is with the 3rd Medical Laboratory, APO 503, Unit No. 1, San Francisco.

* * *

The U.S. Naval Air Station Dispensary at Pensacola, Fla., is the assignment of Lt. (j.g.) Thomas E. Clark, Columbus.

* * *

Three Ohioans are on the staff of the Station Hospital, Camp Chaffee, Ark. They are: Major Edward B. Castle, Cleveland, chief, General Surgical Section; Capt. Irving Cramer, Cleveland, assistant chief, E.E.N.T. clinic; and Capt. Louis Sheinen, Akron, ward officer on the medical service.

* * *

Col. B. N. Carter, Cincinnati, is assistant director, Surgery Division, Office of the Surgeon General, Washington, D.C.

Among the 42 temporary promotions to brigadier generals recently announced by the President, the following were in the Army Medical Corps: Brig. Gen. Joseph I. Martin, Chicago; Brig. Gen. Earl Maxwell, Fort Leavenworth, Kansas; Brig. Gen. Guy B. Denit, Salem, Va.; Brig. Gen. Edgar E. Hume, Frankfort, Ky.

* * *

Lt. John H. Blackburn, Kalida, has been transferred from Camp Grant, Ill., to the 7th Hospital Train, Camp Forrest, Tenn.

* * *

Capt. Chas. O. Butner, Shiloh, 634 Clearing Co., APO 649, New York, writes that he misses the fellowship of the Association and wants *The Journal.* Here 'tis, doctor.

* * *

Major Robert E. Bowman, Cleveland, is with the Hq. 11th Armored Division, APO 261, Camp Cooke, Cal.

* * *

Another Cleveland physician, Major Charles Berns, attached to the 32nd Evacuation Hospital, now has the address of APO 9531, New York.

* * *

Capt. N. R. Baumgartner, Bolivar, is Post Medical Inspector at Ft. Benj. Harrison, Indiana.

* * *

Capt. Welden E. Diller, Rawson, has returned to the United States after serving six months in Australia. He is convalescing from an injury received abroad.

* * *

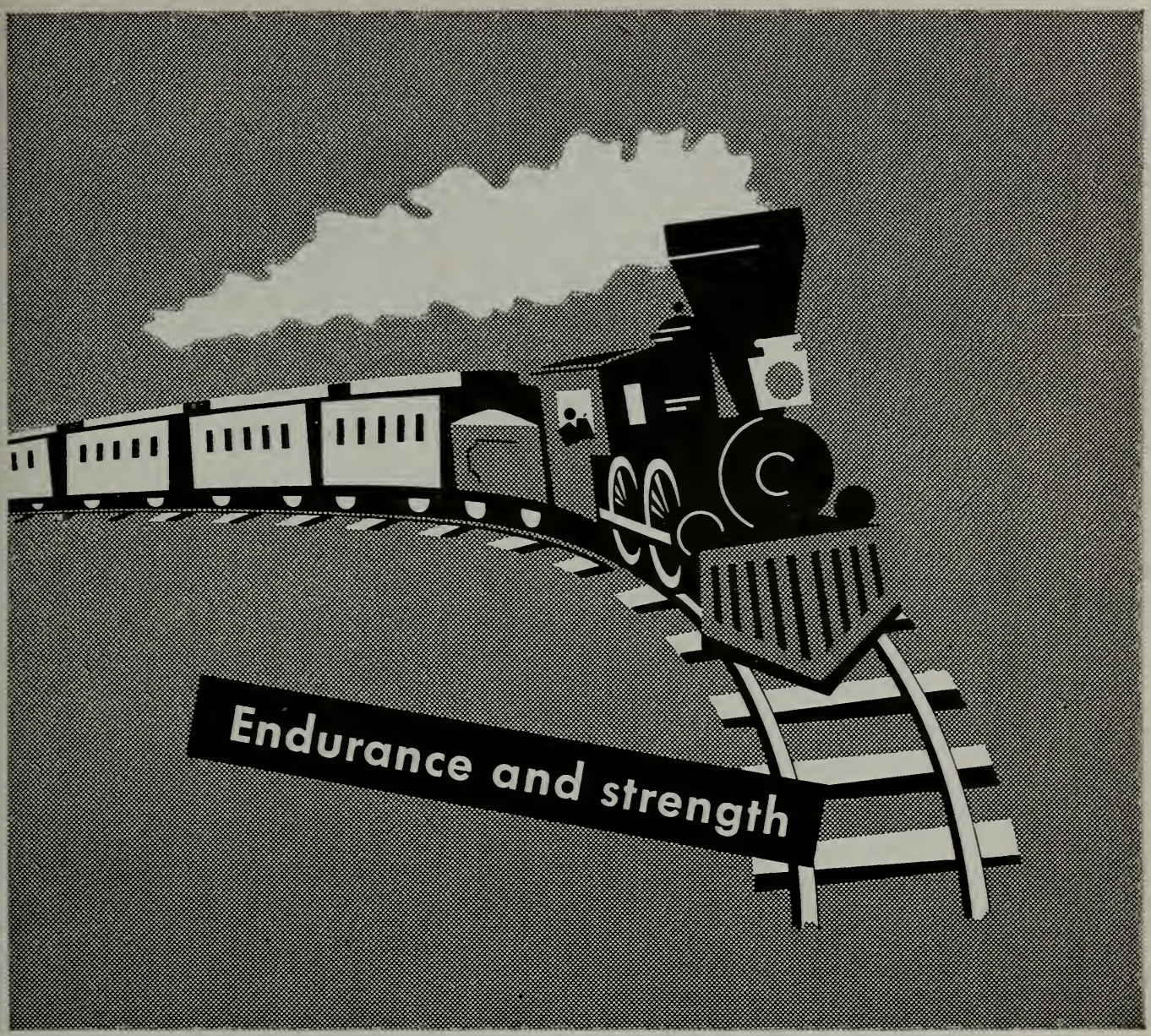
Major Donald A. Miller reports to his Youngstown colleagues:

"I have been associated with the 30th Station Hospital for the past one and a half years and during that period of time we have traveled by sea a distance greater than the circumference of the earth. We have been on foreign duty for fourteen months and located in Persia for eleven of those months. While functioning at more than capacity, our unit was ordered to do the unusual and that was to move from the European to the Asiatic-Pacific Theatre of operations. Our move was rapid but very efficient and here we are located in an area of great import and with a marvelous hospital set-up just nearing completion. Our trip to this part of this theatre was definitely eventful.

"During my association with this unit I have had charge of the surgical service and one which has been moderately active for having been located in such a theatre where medical problems predominate. We are looking forward to a much more active service soon."

* * *

Gratitude of a Guadalcanal native to whom he had given medical treatment was responsible for 1st. Lieut. Ralph L. Phillips' initiation into the native's tribe recently. With appropriate costume and ceremony, Dr. Phillips was re-named



Increased endurance and strength, relief from characteristic asthenia and muscular weakness follow adrenal cortex therapy when these symptoms are due to cortical insufficiency. Such active therapy, promptly administered, may greatly shorten convalescence and, to a remarkable degree, improve muscle tone, general strength and vitality, and capacity for work.

Adrenal Cortex Extract (Upjohn) is uniquely effective in alleviating typical symptoms of cortical insufficiency because it is a natural complex which supplies the multiple action of many active principles possessed by the gland itself.

Adrenal Cortex Extract (Upjohn)

Sterile solution in 10 cc. rubber-capped vials for subcutaneous, intramuscular and intravenous therapy

Upjohn
KALAMAZOO MICHIGAN

ANOTHER WAY TO SAVE LIVES . . . BUY WAR BONDS FOR VICTORY

"La Kuao". A graduate of the Ohio State University College of Medicine in 1942, Lt. Phillips entered the service after completing his internship at White Cross Hospital, Columbus. Following a brief trip to the Aleutians on a hospital ship, he was assigned to an infantry regiment in the Solomon Islands.

* * *

Recently promoted, Capt. Charles A. Bogue is at Camp Atterbury, Ind., with the 36th Portable Surgical Hospital.

* * *

Capt. Samuel Beckerman, Cleveland, was married to 2nd Lt. Vinnie Madge Hoppough, A.N.C., at Carmel-by-the-Sea, Calif., on Dec. 24, 1943. Capt. Beckerman is now overseas with the Med. Det. of the 543 Engrs. Boat and Shore Regiment, APO 565, San Francisco.

* * *

Capt. Harold M. Messenger, a native of New London, was given prominent mention in an article entitled "Doctors on the Fighting Front", in the February issue of the Cosmopolitan. Says the author:

"I once flew out of Guadalcanal with a load of 21 sick and wounded men, shepherded by an Army flight surgeon, Captain Harold M. Messenger, from the little town of New London, Ohio. Only thirty, Captain Messenger had already made thirty-five such trips. Thus, in only four months, he had treated nearly 750 men in flight, men whose troubles ran the whole gamut from malaria to war neurosis."

A graduate of Ohio State University College of Medicine in 1939, Capt. Messenger interned at St. Luke's Hospital, Cleveland, and later was a resident at the Cleveland Clinic.

* * *

Capt. Karl H. Feistkorn, and several other Cincinnati physicians, are with the 25th General Hospital, "somewhere in England".

* * *

"Somewhere in the Aleutians", is the location of Capt. Stanley L. Feldman, Cleveland, with the 179th Station Hospital.

* * *

Capt. S. E. Gates, Conneaut, is with the 527th Armored Infantry Bn., Fort Knox, Ky.

* * *

Close by in Louisville is Capt. Franklin R. Geiger, Cincinnati, who is at Nichols General Hospital, with the interesting assignment of internist attached to the orthopedic service, assigned to the care of the intercurrent disease section and treatment with penicillin of the chronic osteomyelitis cases.

* * *

Comdr. Drew L. Davies, Columbus, is reported to be with a naval hospital unit in the New Hebrides.

Capt. Lawrence C. Goldberg, Cincinnati, is chief of dermatology and syphilology at the new Thayer General Hospital, Nashville, Tenn.

* * *

A graduate of the School of Aviation Medicine, Randolph Field, Texas, in April, 1943, Capt. William W. Herman is in charge of the Flight Surgeon's Office, AAB, Bluethenthal Field, Wilmington, N.C. Capt. Herman is scheduled to receive his flight surgeon's wings within a few months.

* * *

Lt. Comdr. Paul O. Huth, Cambridge, is overseas with the 58th Construction Bn., San Francisco.

* * *

Lt. W. R. Hutchinson, Athens, of the 653rd Medical Hospital Ship Platoon, Camp Stoneman, Calif., has made one round trip to the South Pacific on a hospital ship bringing wounded back to the United States.

* * *

Lt. Comdr. J. D. Hayden, Akron, is medical officer of the Navy V-12 unit at Oberlin College.

* * *

Lt. Comdr. Paul E. Kellogg, Ashland, is with Medical Unit No. 2, U.S. Naval Training Station, Newport, R.I.

* * *

Capt. Albert E. Flagge, Cincinnati, is anaesthetist at the 51st General Hospital, Ft. Bliss, Texas.

* * *

Dr. Arthur W. Thomas, chief of the subdivision of child hygiene of the Cleveland Department of Health and a Captain in the Medical Corps in World War 1, is doubling as a machinist to do his bit in the present war. According to the *Cleveland News*, Dr. Thomas doffs his white coat at 5 p. m., and dons a greasy cap and overalls at six to begin a night shift operating a turret lathe turning out "implements of destruction for the Viking Manufacturing Co."

* * *

Capt. David R. Lewis, Grove City, is at the AAF Replacement Depot, Barksdale Field, La.

* * *

Tinker Field, Oklahoma City, Okla., is the location of Lt. Ray Martz, Hamilton. He is with the 497th Base Hq., and A. B. Sq. Lt. Thomas E. Miller, Ironton, is on the staff of the Station Hospital at Tinker Field.

* * *

Lt. Col. Howard V. Dutrow, Dayton physician, who has served for 27 months as post surgeon and chief of eye, ear, nose and throat service in the station hospital at Borinquen Field, Puerto Rico, has returned to Dayton and will be retired

One case, observed for yourself, is more convincing than a hundred published case histories. Why not have your patients change to PHILIP MORRIS cigarettes, and watch the results! Your *own* observations will mean even more than the published studies, which showed that *on changing to PHILIP MORRIS every case of irritation of the nose and throat* due to smoking *cleared completely* or *definitely improved.**

* *Laryngoscope, Feb. 1935, Vol XLV, No. 2, 149-154*

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—Country Doctor Pipe Mixture. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

from the army March 2, after three years of service, with a medical discharge.

Col. Dutrow was cited in May, 1943, by Col. Bayard Johnson, commanding officer of Borinquen Field, for his work in directing the construction of a permanent hospital at the army field and in helping to reduce malarial and venereal disease rates.

He served as physician with the Isthmian canal commission for the Canal Zone, Panama, from 1905 to 1913; was commissioned a major in the medical reserve corps in 1924 and entered service in 1941. His most recent assignment was at the Nautilus hospital unit, Miami Beach.

* * *

Lt. Col. Roger O. Egeberg, Cleveland, who went to Australia with the Lakeside Hospital Unit about two years ago, has been appointed personal physician to Gen. Douglas MacArthur, according to press dispatches. Detached from his original unit—the Fourth General Hospital—about a year ago, Col. Egeberg has been on duty in New Guinea.

* * *

Major Louis Pillerdorf is chief of neuro-psychiatry at the 1700-bed Battey General Hospital, Rome, Ga. Another member of the staff is Major Robert P. Lytle, Cleveland.

* * *

Capt. Gwyn H. Start, Toledo, is with the 354 Fighter Gp., 355 Fighter Sq., APO 638, New York.

* * *

Lt. Col. Louis E. Lieder, Cleveland, is chief of the Allergy Clinic and General Medical Section No. 2, Walter Reed General Hospital, Washington, D.C.

* * *

Capt. Ray O. Nulsen, Cincinnati, is on the laboratory staff of the station hospital, Camp Claiborne, La.

* * *

"Somewhere in Northern Ireland" is the station of Dr. Abraham Novinsky, Bethel, with the 307 A/B Med. Co.

* * *

Commanding officers of hospitals are now authorized to furnish clinical and professional records of former patients to practicing physicians who may need them for subsequent treatment.

* * *

Lt. Charles A. Obert, Cleveland, writes that his location in the Southwest Pacific would afford a grand opportunity for anyone interested in entomology, "as the specimens are large and numerous". His address is: 209th CA Bn., (AA) (AW), APO 928, Unit 2, San Francisco.

Capt. Cyril E. Myers, Akron, is with the Station Hospital, Camp Cooke, Calif.

* * *

Lt. Col. H. E. Harman, Chillicothe, is CO of the 129th General Hospital, Camp Shelby, Miss.

* * *

Comdr. Harry M. Sage, Columbus, who spent many months afloat on the USS Monticello, is now on duty at Great Lakes, Ill.

* * *

Major Dudley M. Stewart, Toledo, is at Camp Young, Calif., with the 297th Gen. Hosp.

* * *

Not far from home is Capt. Norbert F. Slomer, Port Clinton, on duty at Camp Millard, Bucyrus.

* * *

Previously located at the Air Force Glider Field, Wilmington, Ohio, Capt. Geo. M. Wilcoxon, Alliance, is now at Randolph Field, San Antonio, Texas.

* * *

Lt. Comdr. R. G. Witwer, Cleveland, is flight surgeon, at the U.S.N. Air Station, New Orleans, Louisiana.

* * *

Capt. J. R. Williams, Eaton, is with the Medical Examination Unit, AAF, Miami Beach, Fla.

* * *

Capt. Meyer N. Margolis, Cincinnati, a squadron flight surgeon, has been cited "for extreme heroic daring and risk of life in saving a life from a burning aircraft in Italy in October, 1943". A graduate of the University of Cincinnati College of Medicine in 1938, Capt. Margolis was a resident at Jewish Hospital prior to entering military service.

* * *

Another former resident of Jewish Hospital, Capt. Bernard Burgin, was home recently on a two weeks' leave awaiting reassignment, after having served 20 months with a medical detachment in an infantry division in the South Pacific. He participated in the Guadalcanal campaign and the invasion of New Georgia.

* * *

Major Henry B. Lacey, Columbus, was recently home on leave from the AAB, March Field, Riverside, Calif.

* * *

Army Service Forces Circular No. 30, issued January 26, part 3, contains information concerning the assignment of specially qualified officers to general hospitals, stating that, to the maximum extent practicable, officers of the company grade who have been wounded in action, are classified limited service, are superior in leadership and are physically and mentally suited to such duties will be assigned to duty with detach-



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One level tablespoonful of the Similac powder added to each two ounces of water makes two fluid ounces of Similac. The caloric value of the mixture is approximately 20 calories per fluid ounce.

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ments composed of convalescent patients, especially battle casualties, who are in convalescent reconditioning sections of general hospitals. The primary duty of these officers will be to assist the officer in charge in administrative details and in the military and physical reconditioning of these patients. It is not intended that they replace M. A. C. officers.

* * *

Capt. J. I. Wertheimer, Painesville, is assistant to the chief of surgery, Sta. Hosp., Erie Proving Ground, LaCarne, Ohio. His brother, 1st Lt. Daniel S. Wertheimer, Cleveland, is a member of the neurosurgical staff of the 83rd Gen. Hosp. at Camp White, Oregon.

* * *

Lt. Chas. M. Smith, Portsmouth, is with the Subchaser Training Unit, Miami, Fla., c/o Everglades.

* * *

Lt. Alfred R. Cukerbaum, Youngstown, flew 8000 miles home from the South Pacific for a 15-day furlough. He had been in the South Pacific for 10 months, serving at two naval base hospitals. Lt. Cukerbaum reported that he met three Youngstown colleagues overseas—Lt. Comdr. William Evans, Lt. Samuel Schwebel and Lt. Stanley Myers.

* * *

Capt. Orlando E. Cress had one of his former Cincinnati neighbors, 1st Lieut. John R. Schoenig, as a patient in an Army hospital in England recently. Lieut. Schoenig was suffering from battle wounds received while piloting the Flying Fortress, "Cincinnati Queen".

* * *

Past Asst. Surg. (R) I. G. Sieber, Jr., Cleveland, of the USPHS is on duty with the U.S. Coast Guard, Boston, Mass.

* * *

Major Edgar Northrup, McConnelsville, has been assigned to the Mayo Clinic for a three months' course in internal medicine.

* * *

Post surgeon at Freeman Field, Seymour, Ind., is the new assignment of Major Chas. J. Prochaska, Cleveland. He had been located in Greenville, Miss., for two and a half years.

* * *

Major G. A. Palmer, Akron, was recently transferred from the Station Hospital, Fort Des Moines, Iowa, to the Station Hospital, Fort Snelling, Minn.

* * *

Lt. O. F. Rosenow, Columbus, at the AAF Redistribution Station No. 2, Miami Beach, writes that he still prefers good old Columbus, even with the smoke menace.

Major John E. L. Keyes, M.C., A.U.S., Youngstown, now on duty at the Bushnell General Hospital, Brigham City, Utah, was one of the guest speakers at a meeting sponsored by the Industrial Health Committee of the Utah State Medical Association, January 19, at Salt Lake City.

* * *

Col. Scott C. Runnels, Cleveland, is at the Station Hospital, Camp Patrick Henry, Va.

* * *

Capt. John R. Rohrbaugh, Massillon, is on the staff of the Nichols General Hospital, Camp Campbell, Ky.

* * *

Major Ervin S. Ross, Cincinnati, has been transferred from the AAB, Salina, Kansas, to the 55th General Hospital, Camp Joseph Robinson, Ark.

* * *

Major Thomas H. Rankin, Oxford, is base surgeon at the Army Air Field, Waycross, Ga.

* * *

Major C. W. Sears, Youngstown, has a new address: 313th Sta. Hosp., APO 553, New York.

* * *

Major M. L. Sherman, Dayton, is with the 96th Evac. Hosp., APO 9494, New York.

* * *

Lt. Comdr. H. Vern Sharp, Akron, formerly stationed at Port Deposit, Md., now has a Fleet PO address—Navy 814, New York.

* * *

Mail for the South Pacific Island where Lt. Comdr. C. B. Elliot, Painesville, is stationed, is dropped from the air by means of cargo parachutes manufactured from yarn made by the Industrial Rayon Corporation, Painesville. Dr. Elliott was plant physician for that company before he entered the service.

* * *

Lt. Col. Beecher L. Smith, Columbus, is CO of the 120th General Hospital, Camp Van Dorn, Miss.

* * *

Two Ohioans are attached to the 206th Med. Hosp. Ship Complement, Camp Stoneman, Calif. (Home port). They are: Major Alvin M. Weil, Akron, chief of the surgical service; and Major Harry W. Beck, Canton, chief of the medical service.

* * *

The new address of Major E. B. Junkerman is Station Hospital, Camp Ellis, Ill.

* * *

The first six weeks' class of the School for Medical Administrative Corps Officers began training recently at the Medical Replacement

NUTRITIONAL ANEMIA

in Infants

REASONS FOR EARLY FEEDING OF PABLUM (OR PABENA)

1. The infant's initial store of iron is rapidly depleted during the first months of life. (Mackay,[1] Elvehjem[2]). About 30% of the iron freed from the hemoglobin during the first two months is lost, and while hemoglobin destruction takes place, all infants are in negative iron balance. (Jeans,[3] and Usher, et al.[4]).

2. During the early months of life the infant obtains very little iron from milk — 1.44 mg. per day from the average bottle formula of 20 ounces or possibly 1.7 mg. per day from 28 ounces of breast milk. (Holt,[5] Jeans[3]). The incidence of nutritional anemia has been found to be high among infants confined largely to a diet of cow's milk. (Davidson, et al.[6] Usher, et al.,[4] Mackay[1]).

For these reasons and also because of the low hemoglobin values so frequent among pregnant and nursing mothers (Strauss,[7] and Gottlieb and Strean[8]), the pediatric trend is constantly toward the addition of iron-containing foods at an early age, both to normal infants and those with pylorospasm. (Neff,[9] Blatt,[10] Brennemann,[11] Monypenny[12]).

THE CHOICE OF THE IRON-CONTAINING FOOD

1. Many foods high in iron actually add very little to the diet because much of the mineral is lost in cooking or because the amount fed is necessarily small or because the food has a high percentage of water. Strained spinach, for instance, contains only 1 to 1.4 mg. of iron per 100 Gm. (Bridges[13]).

2. To be effective, food iron should be soluble. Some foods fairly high in total iron are low in soluble iron. Thus egg yolk and liver have less soluble iron than does farina, which is very low in total iron. (Summerfeldt[14]). Oxalate-containing leafy vegetables are low in soluble iron and appear not to be well utilized as a source of iron by infants. (Kohler, et al.,[15] and Stearns[16]).

3. **Pablum (and Pabena) are high both in total iron (30 mg. per 100 Gm.) and soluble iron (7.8 mg. per 100 Gm.) and can be fed in significant amounts at an early age, without digestive upsets. (Blatt,[10] Monypenny[12]). Clinical studies of sick and well babies have shown Pablum to be of value in raising hemoglobin values (Crimm, et al.,[17] Summerfeldt and Ross[18]), even when egg yolk and spinach were not effective (Stearns[16]).**

Pablum, a palatable mixed cereal food, vitamin and mineral enriched, and cooked thoroughly and dried, consists of wheatmeal (farina), oatmeal, wheat embryo, cornmeal, powdered beef bone, sodium chloride, alfalfa leaf, brewers' yeast, and reduced iron. (The oatmeal form of Pablum is called Pabena.)

[1-18] Bibliography on request.

MEAD JOHNSON & CO., Evansville 21, Ind., U.S.A.

Training Center, Camp Barkeley, Texas, to qualify officers for the duties of assistant battalion surgeons serving in battalion aid stations. Under command of the battalion surgeon, each station is in the charge of an assistant battalion surgeon, who at present is a first lieutenant or captain, M. C. The course is being given in an effort to relieve thousands of medical officers for duties more demanding of their complete professional knowledge and is the first of its kind designed by formal instruction to train officers specifically for this work.

* * *

Comdr. W. E. Masters, Columbus, who had been on duty at Quantico, Va., for about two years, has been reassigned to the 14th Naval District, San Francisco.

* * *

"Somewhere in the Fiji Islands", is the location of Lt. Col. Anthony Ruppersberg, Columbus.

* * *

Capt. Samuel W. Weaver, Youngstown, likes his assignment as chief of neurosurgery at the Station Hospital, AAF, Santa Ana, Calif.

* * *

Recent graduates as aviation medical examiners at Randolph Field, Texas, included the following Ohioans; Maj. Carl T. Doeing, Springfield; Maj. David C. Frick, Toledo; Capt. Gilbert E. Garvin, Blanchester; Capt. Edward F. Hellwig, Cleveland; Maj. Benjamin F. Mowry, Findlay; Capt. Benjamin F. Sawyer, North Star; Capt. Merl B. Smith, Toledo; and Capt. George M. Wilcoxon, Alliance.

* * *

Cushing General Hospital, 1750-bed Army hospital at Framingham, Mass., was dedicated January 23 in memory of the late Dr. Harvey William Cushing, noted neurosurgeon and a native of Cleveland. Dr. John F. Fulton of Yale, Dr. Cushing's biographer, delivered the dedicatory address.

* * *

Lt. Comdr. Orville M. Wright, Dayton, staff medical officer at Vella Lavella, Solomon Islands, has just completed one year in the South Pacific combat zone. He has served as flight surgeon with a marine dive-bomber squadron and helped to establish the first recreational and rehabilitation center in the South Pacific.

* * *

Capt. R. K. Ameter, Bryan, has sent home from the Southwest Pacific a Japanese sniper's rifle which was taken from a Jap shot dead in a tree.

Columbus—Dr. Harry W. Topolosky, who has returned to private practice, was guest speaker at a meeting of the Co-operative Club. Dr. Topolosky was severely wounded at Attu while serving as a Lieutenant in the Army Medical Corps.

Help Save Quinidine By Complying With These Recommendations

An acute shortage of quinidine exists in the United States today, and possibilities for replacement of present supplies are negligible. It is imperative, therefore, to reduce the use of this important drug and to limit its employment to the treatment of certain cardiac arrhythmias in which experience has shown it to be of special, often critical, value. The problem of conserving supplies of quinidine has been studied by the Committee on Drugs and Medical Supplies of the National Research Council and its Subcommittee on Essential Drugs and by the Committee on Medicine and its Subcommittee on Cardiovascular Diseases. The following recommendations have been made:

That quinidine be limited to the treatment of heart disease on prescription.

That quinidine should not be combined with other drugs and prepared fixed formulas.

Criteria for the use of quinidine during the period of shortage should be limited to:

1. Ventricular tachycardia diagnosed electrocardiographically.
2. Congestive heart failure that appears definitely to have been precipitated by the sudden onset of auricular fibrillation (if not adequately controlled by digitalis).
3. Persistent premature ventricular contractions in patients who have had acute coronary artery occlusion.
4. Chronic disease of the heart associated with paroxysmal auricular fibrillation, paroxysmal auricular tachycardia or auricular flutter.
5. A history of systemic embolization in a case of paroxysmal or established auricular fibrillation.

Prescription of quinidine should be limited to not more than fifty 3 grain tablets for any acute attack of arrhythmia fulfilling one of the foregoing criteria, and to not more than thirty 3 grain tablets per week for the purpose of maintaining sinus rhythm after quinidine has reestablished it.

Selection of Medical Students

The Directing Board of the Procurement and Assignment Service urges that if at all possible the 20 per cent of places not covered by Army and Navy contracts in classes entering medical schools after Jan. 1, 1945 be filled with students who on graduation will not be obligated for military service: that is, with women and men physically disqualified. This is the only group that can be depended on to serve as replacements for physicians in civilian practice.

Only in case a school does not have a sufficient number of acceptable applicants in this category to fill these places should the number of Army and Navy students accepted exceed 80 per cent. It is urged also that decision to accept more than 80 per cent of students from the armed forces be postponed until the latest possible date.

CHEMOTHERAPY MARCHES ON



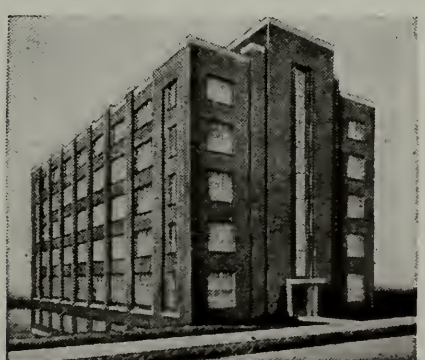
PENICILLIN

Lederle

SEARCH FOR BACTERIOSTATIC AGENTS active in man, but not harmful to him, has proceeded for thousands of years. With the discovery of the sulfonamides the first breach was made in what seemed to be an impenetrable wall across the path of scientific advance. The immense scientific interest in this subject stimulated investigation of other bacteriostatic agents. Old data were re-examined in the light of new developments with at least one outstanding result—*Penicillin.*

In 1929 Fleming[1] was led to publish observations arising from a troublesome phenomenon occurring in plate cultures—contamination with molds. He found that a *Penicillium* mold produced a powerful anti-bacterial substance and suggested that this material might be used for the treatment of infections in man. Not until 1940 however did Chain, Florey[2] and their associates re-examine the prior work of Fleming, confirm his original observations and describe isolation of the active principle—*Penicillin.*

Lederle Laboratories had conducted laboratory research for many years on the growth of molds and the investigation of their products. Today, Lederle is working on a 24 hour schedule to produce Penicillin.



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REFERENCES: [1]FLEMING, A.: Brit. J. Exper. Path. 10: 226 (June) 1929.
[2]CHAIN, E.; FLOREY, H. W.; GARDNER, A. D.; JENNINGS, M. A.; ORR-EWING, J., and SANDERS, A. G.: Lancet 2: 226 (Aug. 24) 1940.

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Licenses To Practice Medicine and Surgery Granted To 243 At February Meeting of State Medical Board

LICENSES to practice medicine and surgery in Ohio were granted 243 graduates of approved medical schools, who passed the December examinations, at a meeting of the State Medical Board, February 8, at Columbus.

Certificates to practice osteopathic medicine and surgery were granted to 11 recent graduates of osteopathic schools. In addition, 145 osteopaths, previously licensed in Ohio, who met the additional, higher requirements prescribed by S.B. 112, passed by the Ohio General Assembly last Spring, were successful in examinations and were granted certificates to practice osteopathic medicine and surgery.

The Board also granted certificates in their respective limited branches to 8 mechanotherapists; 1 chiropractor, 10 chiropodists, 4 masseurs and 3 cosmetic-therapists.

The license of A. A. Aratus, M.D., Cincinnati, was suspended for three months for lending his name and associating himself with an illegal practitioner of medicine.

BOARD ELECTS NEW OFFICERS

The following officers were elected by the Board for the ensuing year: Claude V. Davis, M.D., Pennsville, president; W. M. Hoyt, M.D., Hillsboro, vice-president; J. O. Watson, D.O., Columbus, treasurer. Other members of the Board are: Thos. H. George, M.D., Cleveland; Dwight J. King, M.D., Findlay; Ralph B. Taylor, M.D., Columbus; C. W. Waggoner, M.D., Toledo; and J. H. J. Upham, M.D., Columbus. H. M. Platter, M.D., Columbus, was re-appointed secretary and Prof. S. E. Razor, Columbus, entrance examiner.

Dr. Morton F. Reiser, Cincinnati, a graduate of the University of Cincinnati College of Medicine, made the highest grade, 89.5 per cent, in the December medical examinations. Dr. Don L. Eyler, Cincinnati, a graduate of the Ohio State University College of Medicine, was second with 87.7 per cent. Third place went to Dr. James J. Clear, Cincinnati, a graduate of the University of Cincinnati College of Medicine, with a grade of 87.5 per cent.

THOSE GRANTED MEDICAL LICENSES

The following doctors of medicine were granted licenses:

OHIO STATE UNIVERSITY COLLEGE OF MEDICINE—William C. Baird, Akron; Lloyd J. Barson, Chicago, Illinois; William H. Benham, Toledo; Clark W. Biedel, Athens; William N. Borah, Dayton; William F. Bradley, Columbus; Robert C. Cahill, Columbus; James J. Conn, Columbus; Christie E. Davis, Youngstown; Joseph J. Davis, Peebles; Phillip L. Day, San Antonio, Texas; Gilbert R. Dickerhoof, Lima; Edwin H. Ellison, Columbus; Paul J. Elmlinger, New Washington; Don L. Eyler, Cincinnati; Melvin E. Farris, Lorain; Arthur E. Fouke, Fremont; Morris Fox, Columbus; Robert Franken, Columbus; Stephen L. Gans, Cleveland; Sangwill L. Gernstetter, University Heights, Ohio; Joseph H. Geyer, Columbus; James D. Hayhurst, Columbus; Robert G. Hendershot, Youngstown; Walter E. Horn, Lakeview; William G. Hutchison, Columbus; Charles E. Johnston, Columbus; Milton F. Jones, Akron; James R. Kauffman, Columbus; Leonard A. Kleinman, Glouster; LeRoy F. Kurlander, Los Angeles, California; Anastasius H. Kyriakides, Akron; Joseph T. Leach, Ironton; Moses Leeb, Cleveland; David R. Lehrer, Sandusky; John W. Leist, San Diego, California.

Robert S. McMillen, Jr., Shadyside; Don McNeal, Jr., Cincinnati; Francis G. Mackey, Warren; David E. MacQuigg, Albany, New York; Richard L. Martin, Columbus; Theodore R. Marvin, Elyria; Frank Mauler, Jr., Bucyrus; Frederick E. Mitchell, Bellevue; Marie Moorhead, Columbus; Milton M. Parker, Columbus; Leslie A. Patten, Jr., Columbus; Thomas C. Pomeroy, Wauseon; Carl M. Quick, Mansfield; Robert J. Rohn, Columbus; William S. Rothe, Columbus; Harry M. Sage, Jr., Columbus; David E. Scherr, Toledo; John E. Scheidt, Lima; Wilbert P. Skirball, Ashland; Ivan G. Smith, Columbus; Richard N. Smith, Wooster; Fred Soldow, Cleveland; Richard C. Spear, Columbus; Pearl O. Staker, Columbus; Floyd R. Stauffer, Columbus; Paul R. Stauffer, Brookville; Charles L. Stevers, Columbus; Thomas J. Talbott, Lima; Pasquale S. Test, Youngstown; John C. Trabue, Columbus; Henry N. Westhafer, Columbus; Russell R. Williams, Jr., Columbus.

UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE—Stanley R. Alsfelder, Cincinnati; Irwin H. Altenburg, Cincinnati; Marvin S. Alter, Cincinnati; Maryleen J. Bailey, Cincinnati; William P. Baston, Cincinnati; Victor H. Beinke, Chicago, Illinois; Louis C. Buente, Cincinnati; Paul J. W. Centner, Cincinnati; Emanuel Cheraskin, Upper Darby, Pa.; James J. Clear, Cincinnati, James F. Cleary, Jr., Cincinnati; Clayton B. Conover, Sidney; Sanford R. Courter, Cincinnati; Herbert F. Cowgill, Jr., Crestline; Roland F. Crane, Cincinnati; John F. Dammann, Jr., Winnetka, Illinois; Joseph F. Downey, Cincinnati; Fred D. Droege, Cincinnati; Irvin Dunsky, Cincinnati; Neal N. Earley, Cincinnati; Ervin Ellison, Lancaster, Pa.; Forman Friend, Cincinnati; Robert P. Giesler, Cleveland; Bernard D. Gillman, Cincinnati; Arthur F. Greenwald, Cincinnati; Wyeth Hamlin, Cincinnati; Benton M. Hensler, Anderson, Indiana; Leo E. Hollister, Cincinnati; Thomas D. Hunnicutt, Cincinnati; Donald L. Jacobs, Cincinnati; Robert D. Kiess, Montpelier; Allen E. Kuester, Cincinnati; Albert A. Kunnen, Cincinnati; Horace M. Leeds, Winchester.

Robert C. Lehman, Cincinnati; Robert C. Lewis, Jr., Cincinnati; Max L. Lurie, Cincinnati; Marvin McClellan, Cincinnati; Robert F. Meeko, Cincinnati; Stanley H. Miller, Cincinnati; Edmond H. Niesen, Jr., Cincinnati; Alan H. Nittler, Santa Cruz, California; William D. Paul, Brooklyn, New York; Herman D. Pocock, Jr., Cleveland; Walter L. Pritz, Cincinnati; Richard J. Rehn, Cincinnati; Morton F. Reiser, Cincinnati; Arthur F.



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WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE—Robert L. Adair, Lorain; Hugh R. Anderson, Cleveland; Leonard A. Backiel, Cleveland; Robert C. Bailey, Lakewood; James H. Barr, Jr., Euclid; Raymond J. Barrett, Akron; Edward H. Beilstein, Mansfield; Alma C. Braun, Dayton; Thomas E. Burney, Portsmouth; Robert L. Chase, Akron; Carl W. Christensen, Cleveland; William B. Cleveland, Cleveland; Robert S. Demeter, Lorain; Robert R. Dew, Cleveland; William L. Dittes, Cincinnati; William E. Dwyer, Jr., Cleveland; Franklin J. Grabill, Bainbridge; Walter L. Graham, Jr., Detroit, Michigan; Joseph C. Greene, Valhalla, New York; Thomas J. Hancock, Marietta; David K. Heydinger, Bellefontaine; Jerome C. Hohf, Cleveland; William I. Holcomb, Jr. Kankakee, Illinois; William L. Huffman, Lakewood; Edward C. Janis, Bedford; Water H. Kasserman, Hannibal; John H. Kerrigan, Cleveland; Lloyd H. Klefstad, Duluth, Minnesota; Robert M. Kohrman, Cleveland; James F. Lemmon, Akron.

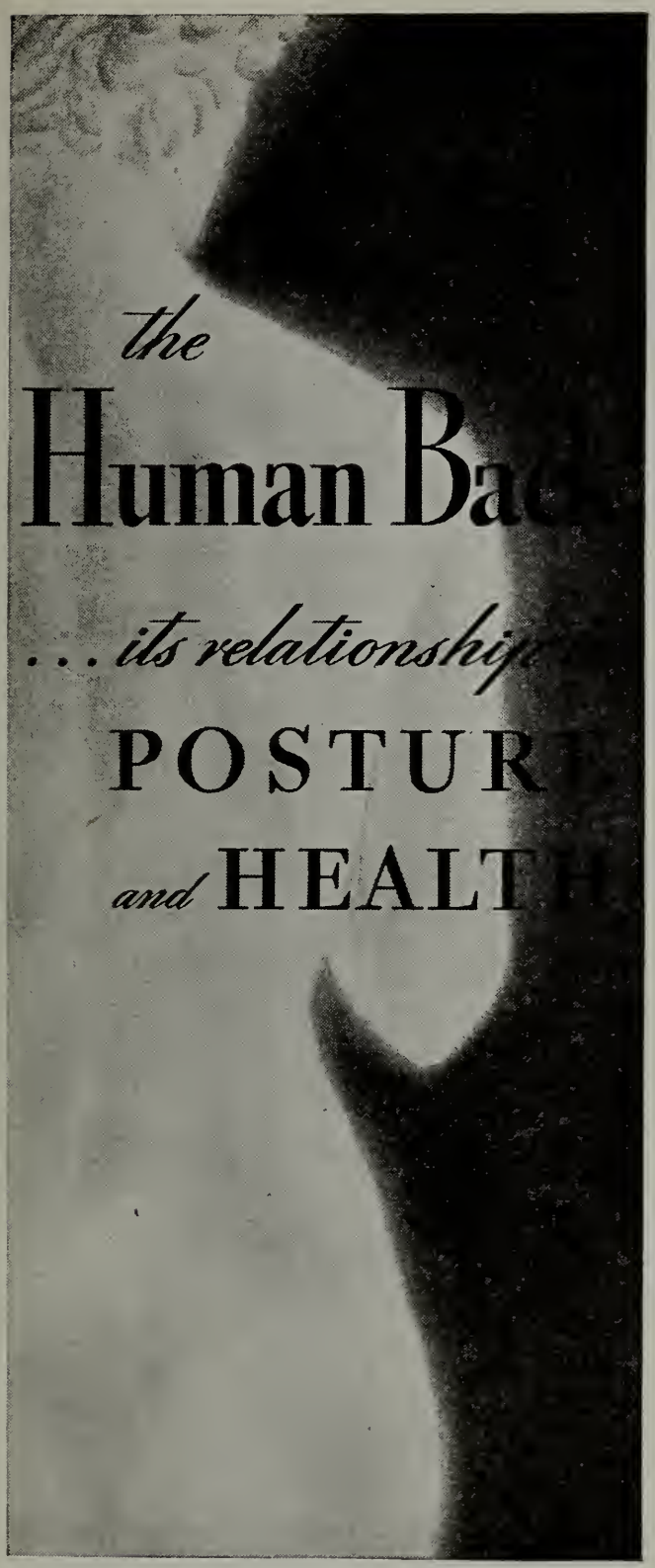
Robert N. Lewis, Cleveland; Joseph J. Lyons, Cleveland; John D. McAllister, Cleveland; James G. Macaulay, Cleveland; Harvey B. McClellan, Xenia; William A. McClellan, Cleveland Heights; Richard J. McConnor, Salem; Ralph E. Meacham, Akron; John C. Mihalek, Cleveland; Durard E. Miller, Monroeville; Arthur F. Millonig, Dayton; Leon H. Moore, Fremont; Lucien E. Morris, Valhalla, New York; Woodrow W. Murphy, Kent; George F. Nevin, Newark, New York; Neil D. Nickerson, Cleveland; Richard G. Nilges, Cleveland; Matthew H. Paushter, Springfield, Massachusetts; Helen E. Peterson, Cleveland; Clark T. Randt, Cleveland; John R. Reed, Cleveland; Robert W. Robinett, Chillicothe; Frank S. Ryerson, Detroit, Michigan; Royden K. Sawyer, Cleveland; Delbert C. Schmidt, Galveston, Texas; Edward A. Shorten, Youngstown; Alfred J. Shreve, Alliance; Quentin B. Smith, Cleveland; Carl W. Uthoff, Toledo; Henry Vogtsberger, Toledo; Donald A. Waag, Dayton; Arnold H. Williams, Wellesley, Massachusetts; Robert F. Williams, Cleveland; Charles E. Willis, Jr., Cleveland; Gordon W. Xander, Columbus; Homer T. Yoder, Cleveland.

GRADUATES OF OUT-OF-STATE SCHOOLS—Charles A. Webster, Jr., Cleveland, Columbia University; John H. Atkins, East Cleveland, Robert F. Gibbons, Toledo, Lane Giddings, Cleveland, Norbert S. Gizinski, Cleveland, George R. Hamilton, East Cleveland, Harry P. Hoffman, East Cleveland, Paul J. Kowallek, Jr., Brecksville, Harry D. McAvoy, Toledo, Robert S. Oyer, Bluffton, Arden S. Turner, Columbus, Hahnemann Medical College; Robert W. Albright, Cleveland, Harvard Medical School; James J. Bayer, Toledo, Vincent T. LaMaida, Cleveland, Frank R. Souers, Akron, Loyola University; Julian W. Buser, Andrew A. Detesco, Youngstown, George C. Kreuter, Toledo, George J. Roncke, Toledo, Paul P. Superfisky, Tiltonsville, Thomas S. Tonnous, Byesville, Marquette University; Roland W. Ayres, Dayton, Harry W. Burnett, Jr., Dayton, Howard C. Miles, Huntington, West Virginia, Northwestern University; Gene D. Chirelli, Youngstown, University of Buffalo; Clinton W. Morgan, Jr., Cleveland, University of Chicago; Alfred S. Gardiner, Middletown, Richard H. Kelty, Canton, University of Michigan; John R. Perkins, Cincinnati, University of Minnesota; Albert W. Monovitz, Cleveland, University of Nebraska; James W. Parks, Akron, Milford F. Townsend, Akron, University of Pennsylvania; Harold W. Brooks, Cleveland, DeWitt E. Harrison, Canton, Albert A. Kattus, Jr., Cincinnati, James C. MacDermott, Jr., Wellington, Russell J. Nicholl, Lakewood, John F. Waldo, Cleveland, University of Rochester; Elizabeth T. Endicott, Cleveland, Wayne University; Edward S. Brown, Cleveland, Yale University; Virginia Hall Goodrich, Marietta, McGill University.

Deaths Among Military Forces in 1943 Are Estimated at 2,000,000

In the present war, military death losses in action for all belligerents amounted to approximately 2,000,000 in 1943, according to a recent release by the Metropolitan Life Insurance Company, New York. Statisticians say that the year 1943 was the second year in succession to show a military death toll of 2,000,000, and the third in which it was on a scale comparable to that of the first world war. The 27,000 American military death losses include deaths among the wounded and an allowance for probable deaths among those now listed as missing. They do not include, however, deaths of Americans in prison camps, of which several thousand have been reported. U. S. military death losses were about double those of 1942. There was a sharp shift in comparative losses between the Army and Navy—the Army battle fatalities were about double those of the Navy (including the Marines and Coast Guard) in 1943, while in 1942 the Navy losses were larger.

Japanese battle deaths in 1943 were estimated to be over 100,000, considerably less than in 1942. The total German losses in 1943 exceeded those in either of the two preceding years, the estimated total being 850,000 and perhaps more than a million. For the first time they exceeded Russian losses, which for 1943 were probably about 600,000. The losses of the countries of the British Empire rose in 1943 to an estimated figure of 75,000 lives. Total losses for other belligerents in 1943 were reported to be considerable, and although Italy was knocked out of the fighting late last summer more than 50,000 Italian soldiers and sailors were killed in battle in 1943. Rumania's losses were reported to be as high as 50,000. Battle deaths of the Chinese were estimated to be between 25,000 and 50,000. Yugoslavs also lost heavily in their guerrilla fighting against the axis, while French units in the military forces of the United Nations lost about 3,000 men.



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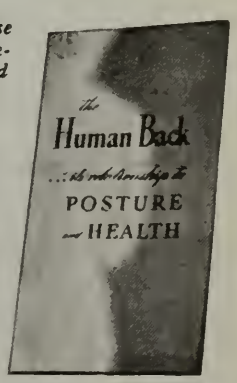
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In Memoriam

Isaac Preston Seiler, M.D., Piketon; Ohio Medical University, Columbus, 1900; aged 67; member of the Ohio State Medical Association and Fellow of the American Medical Association; died January 25. One of Pike County's most widely known citizens, Dr. Seiler had practiced there for 42 years. He was previously located in Arizona for one year. Dr. Seiler was Councilor for the Ninth District of the Ohio State Medical Association for 20 years, 1922-1942, and had always been active in behalf of organized medicine. He was a past-president of the Tri-State Medical Association. During World War I, Dr. Seiler was a 1st Lieutenant in the Medical Corps of the U.S. Army, stationed at Ft. Oglethorpe, Ga. Despite an extensive country practice, Dr. Seiler found time to participate actively in community affairs. He had been president of the local school board for many years, and mayor of Piketon for four years. He was re-elected last November. Dr. Seiler was a member of the Varsity "O" Association of Ohio State University, having won his letter in both football and baseball while in medical school. Until a few years ago he had been an ardent golfer. Dr. Seiler was a member of the Masonic Order and the Methodist Church. His widow, a son, a sister and two brothers survive.

Michael Albert Albl, M.D., Cleveland, Western Reserve University School of Medicine, 1892; aged 75; member of the Ohio State Medical Association and Fellow of the American Medical Association; died February 19. Dr. Albl practiced in Cleveland for 52 years and was a member of the staff of St. Alexis Hospital. Active in Masonic organizations, Dr. Albl was also a member of the Knights of Pythias and the Sokol Czech Havlicek. Surviving are his widow, two daughters, a son and a brother.

Homer Moon Austin, M.D., Columbus; Medical College of Ohio, Cincinnati, 1902; aged 74; member of the Ohio State Medical Association and Fellow of the American Medical Association; died January 20. A resident physician at the Columbus State Hospital since 1933, Dr. Austin was previously associated with the State Department of Health. During World War I he was a captain in the Medical Corps of the U.S. Army. Surviving are his widow, two daughters and two sons, one of whom is Major Marvin Austin, M.C., A.U.S.

Laszlo Joseph Endrey, M.D., Cleveland; University of Budapest, Hungary, 1913; aged 55; member of the Ohio State Medical Association and Fellow of the American Medical Association; died January 28. Dr. Endrey had practiced in Cleveland since 1923. While serving in the Austro-Hungarian Army in World War I, he was taken prisoner by the Russians and held in Siberia for four years. Surviving are his widow, Dr. Irene S. Selymes-Endrey, and a daughter,

Herbert Loring Frost, M.D., Cleveland; Cleveland University of Medicine and Surgery, 1886; aged 84; died February 10. A practicing physician in Cleveland since 1889, Dr. Frost was a member of the staff of Huron Road Hospital. His widow survives.

Charles Meigs Harrison, M.D., Napoleon; University of Michigan Medical School, Ann Arbor, 1892; aged 76; member of the Ohio State Medical Association and the American Medical Association; died January 31. A native of Napoleon, Dr. Harrison practiced there for 52 years. A daughter and a son, Dr. J. Julian Harrison, Napoleon, survive.

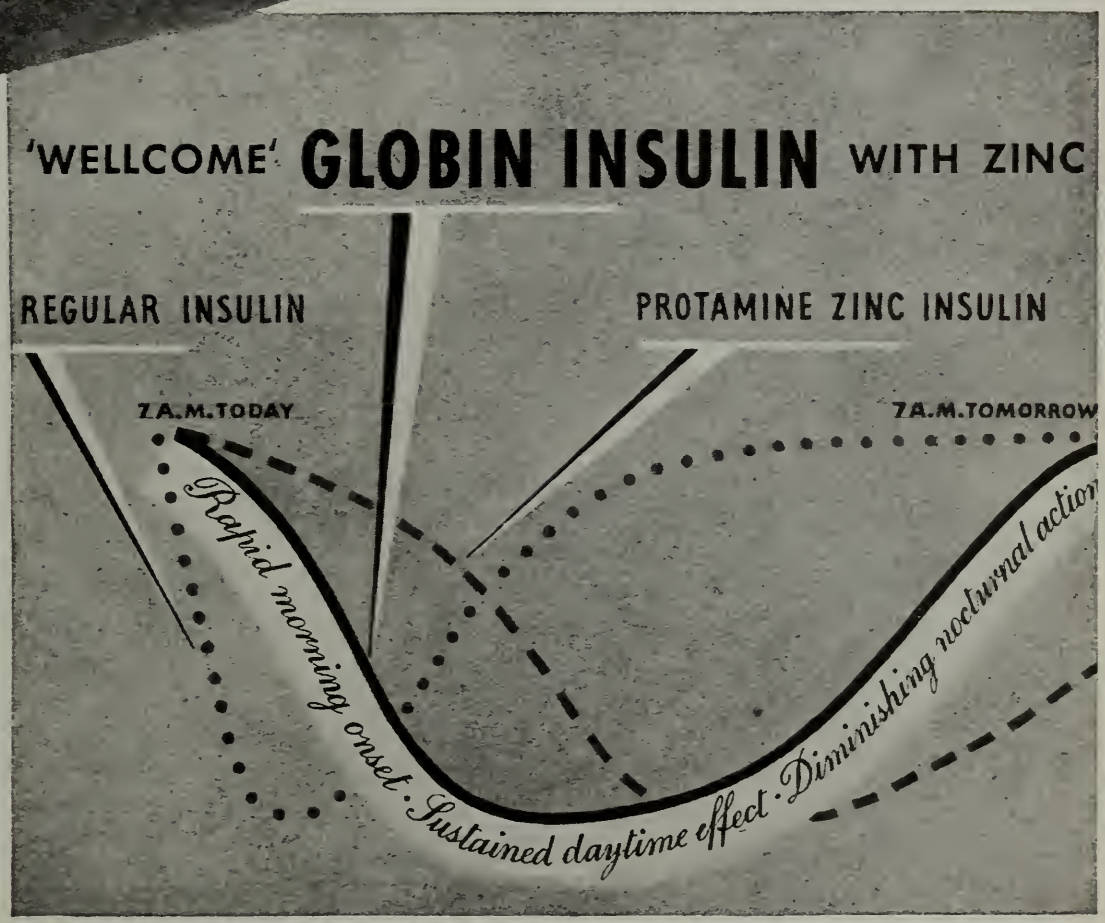
Corwin Thomas Hill, M.D., Akron; Western Reserve University School of Medicine, Cleveland, 1898; aged 74; member of the Ohio State Medical Association and Fellow of the American Medical Association; died January 1. A member of the Summit County Medical Society since 1899, Dr. Hill was vice-president in 1922 and president in 1923. He was one of the founders of People's Hospital. Surviving are his widow, one son and a sister.

Charles Higby Hoffhine, M.D., Columbus; Starling Medical College, Columbus, 1905; aged 61; member of the Ohio State Medical Association and Fellow of the American Medical Association; died February 8. Dr. Hoffhine practiced in Columbus for 39 years. From 1920 to 1923, he was an instructor in ophthalmology at the Ohio State University College of Medicine. He was a member of the staff of Grant Hospital. Dr. Hoffhine was a member of the Masonic order. His widow, a daughter, two sons, and a sister survive.

William Humphrey Johnston, M.D., Norwalk; Western Reserve University School of Medicine, 1889; aged 77; died January 26. Dr. Johnston practiced in Townsend Center, Huron County, for nearly 55 years. He was a Mason. His widow and a son survive.

Clyde Raymond Larkins, M.D., East Liverpool; Jefferson Medical College of Philadelphia, 1903; aged 69; member of the Ohio State Medical Association and Fellow of the American Medical Association; died January 29. A practicing physician in East Liverpool for 40 years, Dr. Larkins was a member of the staff of City Hospital and

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Literature on request

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for many years was chairman of the Board of Trustees. He was a member of the Masonic Order and the Methodist Church. Surviving are his widow and a brother.

George P. Maxwell, M.D., San Benito, Texas; Ohio Medical University, Columbus, 1898; aged 83; died January 20. Dr. Maxwell formerly practiced in Lexington and Sandusky. His widow survives.

Guy Tingley Meek, M.D., Columbus; Starling Medical College, Columbus, 1896; aged 70; member of the Ohio State Medical Association and the American Medical Association; died January 24. Dr. Meek retired several years ago after having practiced in Columbus for over 40 years. During World War I he was a Captain in the Medical Corps of the U.S. Army, serving at Camp Custar, Mich., Camp Crane, Pa., and at a base hospital in France for nine months. From 1919 to 1932, Dr. Meek was a medical examiner for the U.S. Veterans' Administration. He was a member of the Methodist Church, Sons of the American Revolution, the Fraternity of Phi Gamma Delta and the American Legion. His widow and two brothers survive.

Myron Firth Metzenbaum, M.D., Cleveland; University of Wooster, Medical Dept., Cleveland, 1900; aged 68, member of the Ohio State Medical Association, Fellow of the American Medical Association, the American College of Surgeons and the American Academy of Opthalmology and Oto-Laryngology; diplomate of the American Board of Otolaryngology and the American Board of Plastic Surgery; died January 25. Widely known in his specialty, Dr. Metzenbaum practiced in Cleveland for over 40 years. He was a member of the staff of Mt. Sinai Hospital, and the courtesy staff of St. Luke's Hospital. Surviving are his widow, two daughters, four brothers and three sisters.

James Munsie, M.D., Cleveland; Niagara University Medical Dept., 1898; aged 77; former member of the Ohio State Medical Association and the American Medical Association; died January 18. Dr. Munsie closed his downtown office in Cleveland 10 years ago because of ill health, and had since practiced at his home. He was a member of the staff of Polyclinic Hospital and was court physician for the Independent Order of Foresters. Dr. Munsie was a Mason. His widow and two daughters survive.

Milton Ross Ort, M.D., Columbus; Indiana University School of Medicine, Bloomington, Ind., 1938; aged 40; died February 17, on Efate Island in the New Hebrides, while on duty as a Major in the Medical Corps of the Army of the United States. A graduate of the Army's course in tropical diseases at Washington, D.C., Major Ort had served in Panama, Costa Rica, Guatemala and Nicaragua. He went to the South Pacific about six months ago, and after a short time in New Caledonia, was attached to the Navy command under Admiral Halsey as malariologist of the Malaria Control Headquarters of the South Pacific Area. His father and a sister survive.

Louis Ely Papurt, M.D., Cleveland; Western Reserve University School of Medicine, Cleveland, 1924; aged 44; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; diplomate of the American Board of Orthopaedic Surgery; member of the American Academy of Orthopaedic Surgery and Clinical Orthopaedic Society; died February 17. Dr. Papurt practiced in Cleveland for nearly 20 years. He was a member of the staffs of Mt. Sinai, Fairview and Lutheran Hospitals and a consultant at St. John's Hospital. Dr. Papurt was on the medical advisory board of the Cuyahoga County Chapter of the National Foundation for Infantile Paralysis. He was a member of the Rotary Club. His widow, three daughters and a brother survive.

William Thomas Stewart, M.D., Oxford; Medical College of Ohio, Cincinnati, 1908; aged 66; former member of the Ohio State Medical Association and the American Medical Association; died January 23. Dr. Stewart retired four years ago because of ill health. He had practiced in Oxford and vicinity for over 30 years. For many years, Dr. Stewart was president of the Butler County Board of Health. During World War I he served in France as a Captain in the Medical Corps of the U.S. Army. Dr. Stewart was a member of the United Presbyterian Church. Surviving are his widow and two brothers.

John T. Stober, M.D., Lexington; Cleveland University of Medicine and Surgery, 1889; aged 82; former member of the Ohio State Medical Association and the American Medical Association; died January 28. Dr. Stober practiced in Lexington and Richland County for 50 years, retiring two years ago. He had been first vice-president of the Richland County Automobile Club for many years, and was a charter member of the county Board of Health. He was a Mason. Surviving are his widow, two sons, one of whom is Dr. George W. Stober, Cleveland, a daughter and eight sisters.

James William Trisler, M.D., Glendale; Jefferson Medical College of Philadelphia, 1884; aged 86; died January 25. A native of Brown County, Dr. Trisler practiced there for a few years. Later he practiced in Western Kentucky and southeastern Missouri. He retired in 1922. Dr. Trisler was a member of the Masonic Order. Three daughters survive.

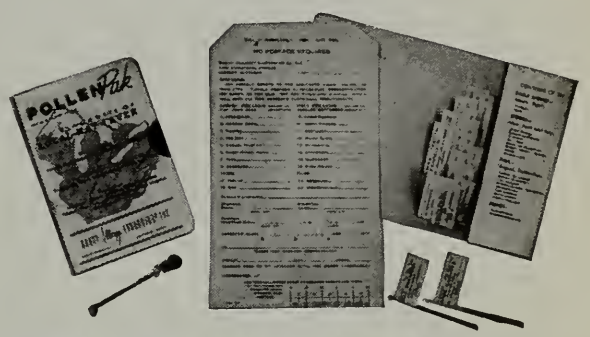
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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

CLERMONT

Dr. George E. Rockwell, Cincinnati, spoke on "Bronchial Asthma", at a meeting of the Clermont County Medical Society, January 26, at the home of Dr. Warren E. Thomas, South Milford.—News clipping.

CLINTON

"Aviation Medicine", was the topic discussed by Capt. George M. Wilcoxon, M.C., A.A.F., formerly of Alliance, at a meeting of the Clinton County Medical Society, February 1, at the General Denver Hotel, Wilmington.—News clipping.

HAMILTON

The Academy of Medicine of Cincinnati presented the following programs during February:

Feb. 1—"The Sympathomimetic Drugs", Dr. Abraham Myerson, director of research, Boston State Hospital and clinical professor of psychiatry, Harvard Medical School.

Feb. 29—"The Proportion of Fat and Carbohydrates in the Diet of the Diabetic Patient", Dr. Elmer L. Sevringhaus, professor of medicine, University of Wisconsin Medical School, Madison, Wisconsin.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

MIAMI

Dr. William Clark of the Kettering Research Laboratory, Dayton, spoke on "Physical Therapy in General Medical Practice", at a meeting of the Miami County Medical Society, February 4, at Stouder Hospital, Troy.—G. A. Woodhouse, M.D., secretary.

MONTGOMERY

A sound movie on "Treatment of War Neuroses", from the Mill Hill Hospital, London, England, was shown at a meeting of the Montgomery County Medical Society, February 4, at the Fidelity Building Auditorium, Dayton.—C. D. Padan, M.D., president.

SHELBY

Officers of the Shelby County Medical Society for 1944 are: Dr. F. R. McVay, Botkins, president; Dr. V. W. LeMaster, Sidney, vice-president; Dr. R. E. Paul, Botkins, secretary-treasurer; Dr. A. B. Gudenkauf, Sidney, chairman, Legislative Committee; Dr. H. C. Clayton, Sidney, chairman, Committee on War Participation; Dr. R. A. Alvis, chairman, Committee on Industrial Health; Dr. H. E. Crimm, Sidney, chairman, Committee on Physical Fitness.—R. E. Paul, M.D. secretary.

Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

ALLEN

A motion picture on "Inguinal Hernia" was shown at a meeting of the Lima and Allen County Academy of Medicine, February 15, at the Lima Memorial Hospital.—C. Badertscher, M.D., secretary.

CRAWFORD

The Crawford County Medical Society has elected the following officers for 1944: Dr. K. H. Barth, New Washington, president; Dr. D. D. Bibler, Bucyrus, vice-president; Dr. Clarence Adams, Galion, secretary-treasurer; Dr. C. A. Marquart, Crestline, chairman, Legislative Committee.—Clarence Adams, M.D., secretary.

MARION

The following Marion physicians are officers of the Marion County Academy of Medicine for 1944: Dr. F. W. Rea, president; Dr. J. A. McNamara, vice-president; Dr. Richard L. Morgan, secretary-treasurer; Dr. Tom Sutherland, chairman, Legislative Committee; Dr. N. Sifritt, chairman, Committees on War Participation, Industrial Health, and Recreation and Physical Fitness.—Richard L. Morgan, M.D., secretary-treasurer.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

DEFIANCE

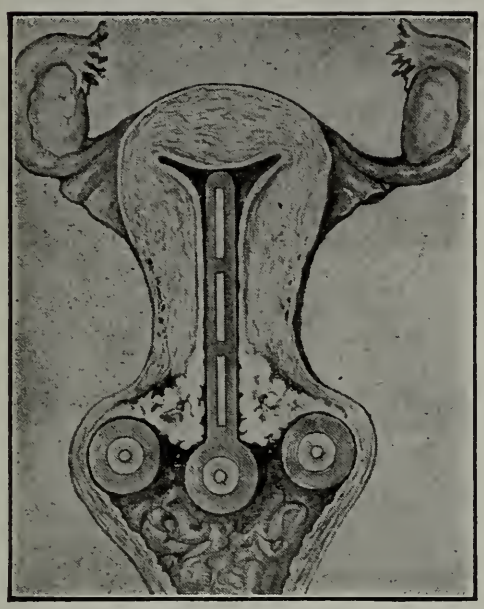
Officers of the Defiance County Medical Society for 1944 are: Dr. George DeMuth, Sherwood, president; Dr. Paul B. Newcomb, Defiance, vice-president; Dr. E. P. Mitchell, Defiance, secretary-treasurer; Dr. J. S. Hull, Hicksville, chairman, Legislative Committee; Dr. D. J. Slosser, Defiance, chairman, Committee on War Participation; Dr. Mitchell, chairman, Committee on Industrial Health; Dr. John Cameron, Defiance, chairman, Committee on Recreation and Physical Fitness.—E. P. Mitchell, M.D., secretary.

LUCAS

The Toledo Academy of Medicine presented the following programs during February:

Feb. 4—General Meeting. "Chronic Indigestion and Its Differential Diagnosis", Dr. H. M. Pollard, assistant professor of internal medicine,

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Feb. 11—Section of Pathology, Experimental Medicine and Bacteriology. Program by members of the staff of Flower Hospital.

Feb. 18—Medical Section. "Penicillin Usage in the Toledo Area", clinical case reports by Lt. Comdr. Fitzgerald, and Drs. H. Kessler, J. L. Stifel, Lawrence E. Clark, Thad Taylor, B. G. Chollett and Ben H. Carroll.

Feb. 25—Surgical Section. "Omental Adhesive Syndrome", Dr. B. G. Shaffer.—Bulletin.

Officers of the Academy for 1944 are: Dr. Paul M. Holmes, president; Dr. John L. Stifel, vice-president; Dr. Rollin Kuebbeler, secretary; Dr. W. W. Alderdyce, treasurer; Dr. A. S. Avery, chairman, Legislative Committee; Dr. Dale Wilson, chairman, Committee on War Participation; Dr. R. H. Elrod, chairman, Committee on Industrial Health; Dr. R. C. Young, chairman, Committee on Recreation and Physical Fitness.—George W. Cooley, executive secretary.

WILLIAMS

The Williams County Medical Society has re-elected the following officers for 1944: Dr. H. R. Mayberry, Bryan, president; Dr. M. R. Kittredge, Bryan, vice-president; Dr. H. J. Luxan, Montpelier, secretary; Dr. H. L. Prouty, West Unity, chairman, Legislative Committee; Dr. Luxan, chairman, Committee on War Participation.—H. J. Luxan, M.D., secretary.

Fifth District

(COUNCILOR: E. P. McNAMEE, M.D., CLEVELAND)

ASHTABULA

Dr. H. S. Van Ordstrand, Cleveland, spoke on "Cancer of the Lung", at a meeting of the Ashtabula County Medical Society, January 11, at Ashtabula.—News clipping.

CUYAHOGA

"The Use of the Newer Insulins in the Treatment of Diabetes", was the subject of an address made by Dr. Henry T. Ricketts, associate professor of medicine, University of Chicago, at a meeting of the Academy of Medicine of Cleveland, February 18, in the Auditorium of the Cleveland Medical Library Association.—Bulletin.

LAKE

Officers of the Lake County Medical Society for 1944 are: Dr. L. W. Judd, Madison, president; Dr. Mabel Pearce, Painesville, vice-president; Dr. B. Fisher, Fairport Harbor, secretary-treasurer; Dr. W. R. Carle, Perry, chairman, Legislative Committee; Dr. J. M. York, Painesville, chairman, Committee on Industrial Health.—B. Fisher, M.D., secretary.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

MAHONING

Dr. Emil Novak, associate in gynecology, Johns Hopkins Medical School, spoke on "Endocrines in Gynecology", at a meeting of the Mahoning County Medical Society, February 15, at the Youngstown Club.—Bulletin.

STARK

New officers of the Stark County Medical Society are: Dr. D. D. Shontz, Massillon, president; Dr. C. F. Schmitt, Canton, secretary-treasurer; Dr. J. M. Van Dyke, Canton, chairman, Legislative Committee; Dr. J. E. Purdy, Canton, chairman, Committee on War Participation.—C. F. Schmitt, M.D., secretary.

Dr. A. S. Harris, Cleveland, spoke on "The Chronic Cough", at a meeting of the Stark County Medical Society, January 20, at the Hotel Onesto, Canton.

SUMMIT

"Hormonal Therapy of Menstrual Disorders", was the subject discussed by Dr. E. Perry McCullagh, Cleveland, at a meeting of the Summit County Medical Society, February 1, at City Hospital, Akron.—Bulletin.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

The following Coshocton physicians are officers of the Coshocton County Medical Society for 1944; Dr. T. F. McAllister, president; Dr. D. S. McDill, vice-president; Dr. H. W. Lear, secretary-treasurer; Dr. E. M. Wright, chairman, Legislative Committee.—H. W. Lear, M.D.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

ATHENS

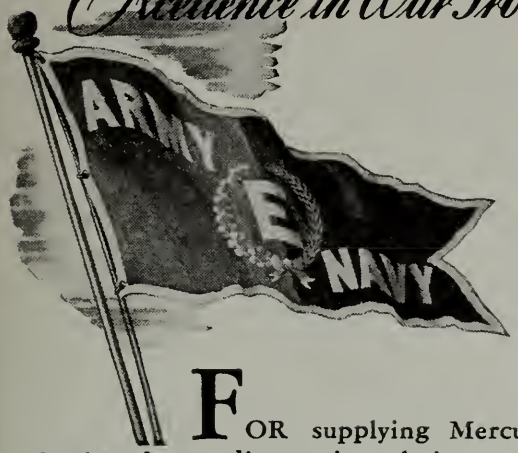
Officers of the Athens County Medical Society for 1944 are: Dr. J. R. Sprague, Athens, president; Dr. H. H. Fockler, Athens, vice-president; Dr. C. R. Hoskins, Athens, secretary-treasurer; Dr. E. LeFever, Glouster, chairman, Legislative Committee; Dr. B. R. Goldsberry, chairman, Committee on War Participation; Dr. W. H. Hyde, Nelsonville, chairman, Committee on Industrial Health; Dr. A. A. Baldwin, Athens, chairman, Committee on Recreation and Physical Fitness.—C. R. Hoskins, M.D., secretary.

Dr. J. W. Means and Dr. C. J. DeLor, Columbus, led a discussion on "Gall Bladder Disease", at a meeting of the society, January 13, at Nelsonville.—News clipping.

LICKING

The Licking County Medical Society has elected the following officers for 1944: Dr. Charles D.

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PERRY

Officers of the Perry County Medical Society for 1944 are: Dr. W. D. Porterfield, Junction City, president; Dr. James Miller, Corning, vice-president; Dr. H. F. Minshull, New Lexington, secretary-treasurer; Dr. James Miller, Corning, chairman, Legislative Committee and Committee on War Participation; Dr. Robert W. Miller, Hemlock, chairman, Committee on Industrial Health.—H. F. Minshull, M.D., secretary.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

GALLIA

The following Gallipolis physicians are officers of the Gallia County Medical Society for 1944: Dr. N. Howard Foster, president; Dr. Paul C. Foster, secretary-treasurer; Dr. Charles E. Holzer, chairman, Legislative Committee and Committee on Industrial Health; Dr. O. A. Vornholt, chairman, Committee on War Participation; Dr. A. Lewis Brown, chairman, Committee on Recreation and Physical Fitness.—Paul C. Foster, M.D., secretary.

Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

FAYETTE

Officers of the Fayette County Medical Society for 1944 are: Dr. A. D. Woodmansee, Washington C. H., president; Dr. K. R. Teachnor, Washington C. H., vice-president; Dr. W. D. Maag, Jeffersonville, secretary-treasurer.—W. D. Maag, M.D. secretary.

FRANKLIN

The Columbus Academy of Medicine presented the following programs during February:

Feb. 7—"The Practical Clinical Importance of the New Rh Blood Group", Dr. Louis K. Diamond, assistant professor of pediatrics, Harvard Medical School.

Feb. 21—"Penicillin—a Potent Chemotherapeutic Agent", Dr. William G. Myers, research associate in chemistry, Ohio State University.—Bulletin.

Officers of the Academy for 1944 are: Dr. William D. Inglis, president; Dr. George J. Heer, president-elect; Dr. Horace B. Davidson, secretary-treasurer; Dr. John M. Thomas, chairman, Legislative Committee; Dr. William B. Morrison, chairman, Committee on War Participation; Dr. Frank A. Riebel, chairman, Committee on Industrial Health.—Stanley R. Mauck, executive secretary.

MADISON

Dr. Robert S. Postle, London, is president and secretary, and Dr. W. A. Holman, London, is chairman of the Committee on War Participation of the Madison County Medical Society for 1944.

MORROW

Officers of the Morrow County Medical Society for 1944 are: Dr. F. M. Hartsook, Cardington, president; Dr. C. S. Jackson, Mt. Gilead, vice-president; Dr. F. H. Sweeney, Mt. Gilead, secretary-treasurer; Dr. E. C. Sherman, Cardington, chairman, Legislative Committee; Dr. W. L. Murphy, chairman, Committee on War Participation; Dr. C. S. Jackson, chairman, Committee on Industrial Health; Dr. J. G. Ingmire, Mt. Gilead, chairman, Committee on Recreation and Physical Fitness.—F. H. Sweeney, M.D., secretary.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

ASHLAND

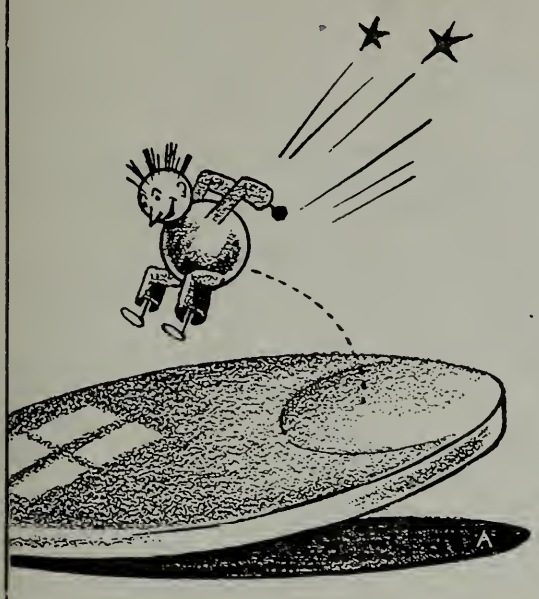
The annual "Ladies Night" of the Ashland County Medical Society was held at the Ashland Country Club, January 28, with wives of the members as guests. Following dinner, a short business session was held. Dr. M. D. Shilling was re-elected delegate to the Ohio State Medical Association and Dr. R. P. Bogniard, alternate. The society voted a sum of money to be spent on publicity against the Wagner Bill. The entertainment feature of the evening was a very interesting talk by Paul Donley, who showed movies of some of his annual fishing trips in the "bush" country of Northern Canada.—Reid P. Joyce, M.D., secretary.

HOLMES

The following Millersburg physicians are officers of the Holmes County Medical Society for 1944: Dr. Neven P. Stauffer, president; Dr. A. J. Earney, secretary-treasurer; Dr. A. T. Cole, chairman, Committee on Industrial Health and Legislative Committee; Dr. J. C. Elder, chairman, Committee on War Participation; Dr. J. M. Jones, chairman, Committee on Recreation and Physical Fitness.—A. J. Earney, M.D., secretary.

RICHLAND

Officers of the Richland County Medical Society for 1944 are: Dr. John F. McHugh, Shelby, president; Dr. C. L. Hannum, Plymouth, secre-



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tary-treasurer; Dr. Charles Keller, Mansfield, chairman, Legislative Committee; Dr. J. F. Morey, Mansfield, chairman, Committee on War Participation; Dr. E. D. Dowds, Shelby, chairman, Committee on Industrial Health; Dr. Myron Reed, Mansfield, chairman, Committee on Recreation and Physical Fitness.—J. F. McHugh, M.D., retiring secretary.

LORAIN

"Leukemia" was the topic discussed by Dr. Russell L. Haden, Cleveland, at a meeting of the Lorain County Medical Society, February 8, at the Lorain Country Club.—L. H. Trufant, M.D., secretary.

Woman's Auxiliary News

ANNUAL MEETING

The Fourth Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association will be held at the Deshler-Wallick Hotel, Columbus, May 2, 3 and 4, concurrently with the 98th Annual Meeting of the State Association, to be held at the Neil House. Mrs. John Earl Briggs, Columbus, is Convention Chairman. Details concerning the meeting will appear in a subsequent issue of *The Journal.*

FRANKLIN

Dr. Robert E. S. Young spoke on "Industrial Medicine" at a meeting of the Woman's Auxiliary to the Columbus Academy of Medicine, January 31, at the Columbus Gallery of Fine Arts. Mrs. R. S. Fidler was chairman of hostesses.

Twenty-nine members of the Auxiliary have enrolled in a course on current community and city health problems being conducted by Mrs. Ralph W. Hoffman, chairman of education.

HAMILTON

Members of the Woman's Auxiliary to the Cincinnati Academy of Medicine have been commended by the City Board of Health for their assistance in the physical examination of high school students, and at the Max Stern Heart Station.

LUCAS

The Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County held a joint dinner meeting with members of the Academy at the Commodore Perry Hotel, Toledo, January 27. Wives of members of the Academy in service were guests. The program included an address by Dr. Jonathan Forman, editor of *The Ohio State Medical Journal.* Members of the Auxiliary in charge of arrangements were: Mrs. J. E. Minns, Mrs. C. E. Price, Mrs. Paul Holmes and Mrs. Wilbur Taylor. Mrs. A. A. Brindley arranged for the transportation of the guests. Mrs. W. W. Beck is president of the Auxiliary and Mrs. C. J. Paule is publicity chairman.

Postgraduate Day Revived

The Mahoning County Medical Society has revived its Annual Postgraduate Day which was not held last year because of war conditions. Usually one of the best medical meetings in the state, the program this year will be given by two members of the faculty of Georgetown University School of Medicine, Washington D. C., and Drs. E. C. Baker and Dean Collier, Youngstown. The meeting will be held at the Hotel Pick-Ohio, Wednesday, April 19. Details of the program may be obtained by writing the office of the Mahoning County Medical Society, 1204 Central Tower, Youngstown.

The Seventh Annual Postgraduate Course in Ocular Surgery, Pathology and Orthoptics sponsored by the George Washington University School of Medicine, will be held at Washington, D.C., April 24-29. For further information, write the secretary, Miss Louisa Wells, 927 17th St., N.W., Washington, D.C.

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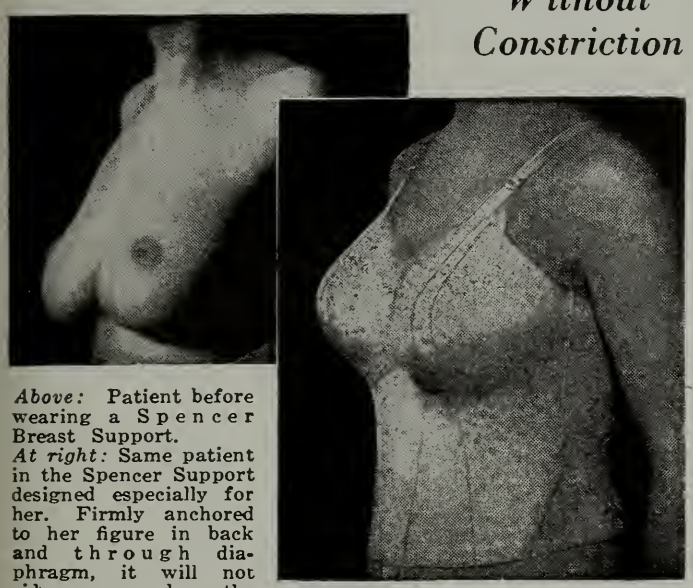
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The Physician's Bookshelf

The Mind of the Injured Man, by Joseph L. Fetterman, M. D. ($4.00. *The Industrial Medicine Book Co., Chicago, Ill.)* is a very good book and a very timely book. We all shall have increasing need for better understanding of the physical, emotional, social, and economic suffering which injury causes both in our returning fighting men and in our industrial workers.

My Flight to Totem-Land. A Tourist Guide, by Louis R. Effler, M.D., Toledo (1943. Published privately) describes the flight and cruise up the "Inside Passage" from Seattle to Skagway Alaska, with a study of the totem-poles en route and other Alaskiana. Like the others of this flight series, it is educational. It is all the more welcome still, since totem-poles have had all too little written about them.

Nutritional Deficiencies. Diagnosis and Treatment, by John B. Youmans, M.D. ($5.00, 2d edition. *J. B. Lippincott Co., Philadelphia)* makes its appearance only 18 months after the first edition. To the valuable material in the first edition has been added more on the changes in the eye on vitamin A deficiency and the use of vitamin A blood determination and much new material on the other vitamins. It is a worthwhile addition to any physician's library.

Health Instruction Year Book, compiled by Oliver E. Byrd, Ed.D. ($3.00. *Stanford University Press, Santa Clara, Calif.)* sets forth under current problems the contribution from the current literature. It is intended that it shall become an annual. It does bring together and summarizes the writings of the year in a form which is readily available for text or reference use.

Synopsis of Clinical Syphilis, by James Kirby Howles, M.D. ($6.00. *C. V. Mosby Co., St. Louis)* does an excellent job of compressing a big topic into 671 small pages.

The Biochemistry of Malignant Tumors, by Kurt Stern, M.D., and Robert Willheim, M.D. ($12.00. *Chemical Publishing Co., New York City)* is a good attempt to intergrate biochemical research in the field of cancer. One is impressed that in recent years there has been a remarkable increase in our knowledge about cancer. It must be on the shelves of all who are interested in cancer.

Behind the Universe. A Doctor's Religion, by Louis Berman, M.D. ($2.75. *Harper & Brothers, New York City)* is by the well known popular writer on endocrinology who now gives us his guess of what lies behind the world of surface experiences. With more and more scientists writing of their faith, this takes a prominent place among these confessions.

Pathology and Therapy of Rheumatic Fever, by Leopold Lichwitz, M.D. ($4.75. *Grune and Stratton, Inc., New York City)* is a challenging book which presents a study of this disease in terms of dynamics. "Rheumatic fever", the author states, results not from a bacterial invasion but from a fault in the mechanism of defense". Here we get a masterful interpretation of the role that allergy plays in the production of rheumatic fever. Every physician and health worker should read this thought provoking volume.

A Surgeon's World. The Autobiography of Max Thorek, M.D. ($3.75. *J. B. Lippincott Co., Philadelphia)* is the story of a great surgeon. It is more, it is an American epic of an emigrant from the teeming slums to chief surgeon of a great hospital. Excellent and inspiring reading.

Synopsis of Materia Medica, Toxicology, and Pharmacology, by Forrest Davison, Ph.D. ($6.50, 3rd edition. *C. V. Mosby Co., St. Louis)* comes as evidence of the cordial reception given to the other editions. There is much that is new about sulfonamides, vitamins of the B-complex and K, hormones, and disinfectants.

Health and Hygiene, by Lloyd Ackerman of Western University. ($5.00. *The Jaques Cattell Press, Lancaster, Pa.)* is a comprehensive study of disease prevention and health promotion. Dr. Ackerman points out how, by the proper yardstick of hygienic measures, millions of cases of illness can be prevented each year in our nation; how we can increase our life span and eliminate many physical, mental and social ills. It is a great book for us physicians to use in our crusade for better health and less emphasis on whether pills shall be distributed at the taxpayer's expense.

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JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.* GEORGE H. SAVILLE, *News Editor*

Traumatic Encephalopathy: With Case Reports

HARRY A. LIPSON, M.D., EDWARD ZUCKER, M.D., and LOUIS J. KARNOSH, M.D.

WITHIN the last decade particularly, the relation between head injury and mental disease has become a highly debatable subject and with the development of laws tending to place the responsibility for accident and injuries, the whole subject has become one of great practical importance. In consecutive case studies at Cleveland City and Cleveland State Hospitals less than ½ per cent of admissions were the psychoses diagnosed Traumatic Encephalopathy. When a comparison is made between these figures with the figures for the organic or functional psychoses, it would appear that the psychoses due to head injury are not very frequent. Yet, it is recognized that there is a definite increase of head injuries yearly and which is very important very often the factor of trauma may be overlooked in the etiology of psychoses. We all know that no two injuries are exactly alike and that a wide variation of symptoms may present themselves both as to type and as to time of appearance.

In general, these patients are brought first to the general hospital where frequently mental aberrations are seen following or accompanying head injury. But so often these patients are discharged because in most cases the early psychotic manifestations are of a temporary nature and clear up promptly when the state of consciousness returns to normal.

Other investigators have observed that trauma to the head or for that matter to any part of the body may occasionally serve as the immediate precipitating agent producing a delirium tremens, a schizophrenia, a manic-depressive phychosis; often individuals suffering from syphilis have been seen who following a rather mild blow to the head develop a full blown dementia paralytica. It is important also to realize that very often cases present mixed clinical pictures so that frequently psychogenic symptoms are superimposed on a true organic syndrome.

Bowman and Blau[1], state that it has been long recognized therefore that a certain group of these mental changes bore only an indirect relationship to trauma which acted as precipitant on a pre-existing psychopathic personality, rather than the direct etiologic agent. So that these mental conditions were properly placed with the "endogenous psychoses", yet, on the other hand, a group of organic mental syndromes could be delineated as definite post-traumatic psycopathies for which the name Post Traumatic Encephalopathy could be well given. This latter group may be quite small in relation to the total number of head injuries yet we believe they belong to an important definite entity and

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● Dr. Zucker, Cleveland, Ohio, is a graduate of Ohio State University College of Medicine, 1938; clinical instructor in nervous disease, Western Reserve University.

● Dr. Karnosh, Cleveland, Ohio, is a graduate of Western Reserve University School of Medicine, 1920; director of neuropsychiatric service, Cleveland City Hospital; associate clinical professor of nervous diseases, Western Reserve University.

Submitted November 8, 1943.

we present the following cases as representative of this syndrome.

CLASSIFICATION

In the standard classified nomenclature of diseases, under the heading, Mental Disorders, the group, Psychoses due to Trauma (Traumatic Psychoses) with the following subheadings occur.

I. Traumatic Delirium
II. Post-Traumatic Personality Disorders
III. Post-Traumatic Mental Deterioration
IV. Other Types, (to be specified) such as Post-Traumatic Defect Conditions, Post-Traumatic Convulsive Disorders, etc.

We have used the same classification in the study of these cases.

PREDISPOSING CAUSES

Many investigators have noted that alcoholism appears to be an important factor in the production of Traumatic Psychoses. The acute and chronic alcoholic is particularly likely to suffer injury, cerebral or otherwise as a result of fights, falls, automobile and other accidents. Others have noted a much disputed relationship between trauma and psychopathic conditions such as neuro-syphilis, arteriosclerosis, senility, psychoneurosis, schizoid and cyclothymic personalities. Wechsler[2] states that the laity, the courts, neuropsychiatrists recognize two sets of facts. Thus if a person is perfectly well before he received a blow to his head and disease began only after this happened, one is dealing with one set of facts. But if the individual already had signs of his illness which can be and is generally non-traumatic, we are dealing with another set of facts.

In our series, it can be seen that these patients came to the psychiatric hospital very often many months after they received their trauma. In most of them the signs and symptoms necessary to satisfy the criteria set by Kennedy[3] as sufficient to produce organic changes in the brain were present. A number of them showed Roentgen evidence of skull fracture, others showed bloody spinal fluid or bleeding from ears, and others showed evidence of focal palsies, or convulsive state following the trauma. There is enough evidence in these cases to show that the injury to the head or brain was sufficiently severe or continuous to be able to initiate or aggravate a pathological process. The disease in most of these instances occurred in the part of the nervous system which had sustained the injury. In most instances the patients were well before the injury.

PATHOGENESIS

Mental sequellae may arise after slight as well as after severe head injuries. Very frequently there is not even a skull fracture present. Often psychoses appear when the main lesion is not even in the brain but the underlying condition may be subdural or epidural hemorrhage. In main, a study of the literature reveals that in the production of the traumatic psychoses the finer histopathological changes are very important. The history of multiple punctate hemorrhages, wide-spread alterations in the ganglion cells and nerve fibers and reactive glial changes which are later followed by secondary changes due to the alterations in brain structure and physiology.

MECHANICS OF INJURY

It is now known that when the head is struck by a moving object the skull at the site of impact, even though there is no fracture of the skull, is likely to be momentarily indented so that its under surface impinges upon the subjacent cerebral or cerebellar cortex. The amount of local injury depends upon the violence of the impact between the skull and the brain and upon the configuration of the inner surface of the bone at the site of impact rather than upon the violence of the impact between the skull and external object. The result of the impact of the inwardly moving skull against the brain may be the production of local superficial injury or a combination of local and remote cerebral injuries. Frequently the remote injuries are more severe than the local one.

Moritz[4] states that a plausible explanation for diffuse cerebral injury so often encountered following head injuries is the hydraulic effect of a sudden severe reduction in intracranial volume. Since the skull is not a closed space, as a result of the momentary indentation caused by the blow, its volume is reduced and both blood and cerebrospinal fluid are probably displaced from it. The sudden rapid movement of fluid within the skull as a result of its altered volume is an important potential source of injury and has been long regarded as a possible explanation of the subependymal petechiae so often seen in the fourth ventricle. It has been suggested that these hemorrhages are caused by the wave effects of the suddenly displaced intraventricular fluid.

A plausible explanation for the immediate loss of consciousness which so often follows head injury is acute cerebral ischemia. If such an injury terminates in death and if sufficient time elapses between injury and death, it is usually apparent in autopsy that the disturbance has been diffuse rather than confined to any one part of the brain.

W. W. Scott[5] has recently shown that in experimental animals even a momentary elevation of intracranial pressure above that of the systolic blood pressure may result in loss of consciousness.

Of the various pathological changes which

may occur as a result of agitation of the brain substance the occurrence of petechiae throughout the white matter is the most characteristic.

A particularly interesting phenomenon associated with head injury is the apparent increase in the vulnerability of the cerebral hemisphere to injury which may be induced by the application of repeated mechanical violence.

Focal degeneration and necrosis, a peculiar form of non-hemorrhagic focal cortical degeneration originally observed by Spielmeyer[6] may be encountered in recently traumatized brains. These lesions consist of small lightly stained, poorly circumscribed and relatively acellular foci. According to Ricker the anoxemia responsible for their development is caused by reflex vasomotor degeneration.

CEREBRAL LOCALIZATION

The present trend among neuropsychiatrists is to regard the brain as an organ functioning as a whole. Many considered the prefrontal area of the brain possesses special influences over behavior and intelligence. In man it has been customary to suppose that frontal lesions tend especially to be associated with deterioration of the personality showing itself in loss of finer feelings, childishness and intellectual and emotional decay. The famous "Crowbar Case" is often quoted. In 1848, in Vermont a man had an iron bar driven through the frontal region of the brain, but lived for twelve years after this. Autopsy showed that only the prefrontal cortex was involved. He had been a most efficient worker, but after the accident his disposition was so changed that he could not hold his former position. Our case R. M. presented a somewhat similar personality, is now living six years after the accident but has become a state inmate due to severe personality changes.

In this dissertation an attempt is made to present the examples of the four major types with the significant sub-classifications.

I. TRAUMATIC DELIRIUM

Very severe cranial injuries are usually fatal immediately, or those individuals die during the original state of unconsciousness without uncovering other mental symptoms. Such patients are usually seen in psychiatric consultation in the emergency room of the general hospital.

CASE I: Traumatic Coma and Delirium; Death.

J. E., 46-year-old, white, married man was driving his automobile which was struck by another machine. He was thrown out of his car, his left side of his head striking a telegraph pole. When seen, spinal fluid was exuding from both nostrils and both ears. He was extremely restless, quite noisy, combative, irrational, confused, was incontinent for urine and feces and died seven hours after the accident.

In minor injuries the individual is merely stunned or dazed for a few seconds or for a few moments. Between these two preceding conditions there may be a great variety of acute and subacute conditions such as confused states, severe deliria and protracted Korsakoff psychoses.

CASE II: Traumatic Delirium; Recovery.

F. K., 32-year-old, white, single male was brought to psychiatric hospital because he was wildly excited, very noisy, abusive and difficult to manage after he had struck his head against the wall of the police cell. The trauma was sufficient to precipitate this wild delirium which was finally quieted down with 15 grains of sodium amytal (7½ gr. I. V. and 7¼ gr. I. M.) and six drams of paraldehyde. About 12 hours later this individual's behavior was perfectly normal. X-ray of skull was negative for fracture.

CASE III: Traumatic Coma, Delirium, and Korsakoff Syndrome.

E. B., 52-year-old, white male brought to the surgical service, Cleveland City Hospital by police following a fight. On admission he had ecchymosis of right eye, bloody spinal fluid, no evidence of fracture of skull by X-ray and no specific localizing neurologic signs. Blood and spinal fluid and Wassermann test were negative. He had a mild fever for about 10 days. Cerebrospinal fluid gradually became clear. At first his sensorium varied from coma to stupor for he was confused, irritable, resistive, uncooperative and required full restraint. He was overtalkative, rambled in his conversation, was disoriented for time, place or person. Within a few days he improved gradually, became less confused and more cooperative. His orientation continued to be poor and he confabulated a great deal and showed no understanding concerning the nature of his disability. He stated that he was visiting a member of his family and was just resting before meals. When asked how he obtained his "black eye", he stated that a horse kicked him. Late in the second week following his trauma he became more cheerful but retained an amnesia for the accident or "fight" and for the early period in the hospital.

CASE IV: Traumatic Delirium, Transitory Confusional Periods.

C. T., a 47-year-old woman, had a short-lived delirium with transitory confusional periods several months thereafter. Her periods were scanty at time of injury. The trauma was probably augmented by menopausal instability. When she attempted to adjust herself to the tensions and problems of her household, she became quite psychotic and became a state patient where she has remained for the last four years. She would not cooperate for X-ray of skull or electroencephalographic studies.

II. POST-TRAUMATIC PERSONALITY DISORDERS OF ADULTS

Post-traumatic personality disorders are late chronic sequelae of head injury. These are organic mental disorders which follow head injury and are characterized by a distinctive personality change. This condition is usually not accompanied by focal neurologic signs. Unfortunately the pathology very often cannot be investigated because of the scarcity of the material.

Blau[1] suggests, on the basis of the absence of focal signs, the marked personality change, that the main lesion may be situated in the prefrontal region since there is a high incidence of frontal fractures in a goodly number of cases.

In most instances these cases do not come to the attention of the psychiatrists until many years later. Puberty accentuates the personality difficulties in many cases as well as increasing the likelihood of misbehavior in the sexual field. The following cases are rather representative.

CASE V: Post-Traumatic Personality Disorder, Schizoid Personality.

A. P., 25-year-old white male who showed rather asthenic body build and who has apparently been a sheltered creature for the last nine years. On the physical side he showed certain stigmata which had to be evaluated before a final diagnosis could be offered.

The story that at the age of six he was struck by an automobile and injured must not be discounted entirely, although the members of the family are inclined to make this the prime deciding factor. If it be true that it was necessary to hospitalize him for 10 days and if it be also true that he had an incontinence for several years after the accident along with definite personality changes then the possibility of an aplasia of the central nervous system following trauma must be considered. However, this trauma to a young brain has not resulted in a frank oligophrenia. Consistently he showed an I.Q. in the high eighties. His vocabulary is that of an adult with average intelligence. His behavior at City Hospital was that of a neurotic man who does not show any defense mechanisms, was decidedly nonaggressive, rather pliant, and docile. During observation period he offered no ego-saving mechanism or rationalizations. He candidly admits that he must have been lazy, that he slept most of the day and stayed up most of the night, that he refused to do the small chores about the house, and that he made no attempt to go out and get a job. This self-derogatory attitude he offered without any tension, any anxiety or other compensation. It was apparent, therefore, that he was content to operate at a psychoneurotic level but at the same time admitted that he had some deficiencies which are capable of correction. He promised to become more aggressive and more accommodating to members of his family.

Because he was not basically oligophrenic, because he showed no hostile or aggressive behavior, and because he was a recessive, chronically psychoneurotic individual, it was decided not to commit him. He has a very bad myopia, his teeth are in poor condition, and he showed other evidences of an individual who has not been able to take care of his general health. While the psychoneurotic symptoms are outstanding and while one may see that he has a psychopathic inferiority, we must not lose sight of the fact that this may be a remote post-traumatic deficiency. Since he was discharged from his observation period at City Hospital his behavior became more psychotic and for last several years has been in Cleveland State Hospital.

Electroencephalographic studies made on this patient revealed much normal 10 per second alpha rhythm. In the left frontal region slow waves with a frequency of four to six per second were found. These suggest a possible encephalopathy.

III. POST-TRAUMATIC PERSONALITY DISORDER—PSYCHOPATHIC PERSONALITY

CASE VI:

S. L., 23-year-old white male, got along very well at home up until July, 1937, at which time he became quite irritable and would lie around all day, was untidy, and would forget to do things asked of him. There was also some friction at home between the patient and his parents because of his girl friend. His parents disapproved of his going with a show girl and were very frank about her. The girl visited the parents' home once. The patient often exhibited extreme nervousness when he telephoned the girl, would grow pale, would perspire freely and seemed to be quite tense.

According to the family, the present illness began in July, 1937, at which time the patient was in an automobile accident. He apparently without reason ran into a safety zone. Following this he was unconscious for two days and then gradually regained consciousness over a period of five days. X-ray revealed no fractures of the skull. Following this accident, as stated above, he was more nervous and irritable than he had previously been.

In 1939 the parents noticed a distinct personality change coincident with the time he began to keep company with the show girl. He began to drink at this time, attended parties and refused any criticism of his girl friend. Later he grew untidy, remained in his room most of the time or about the house and spent much of his time either in a darkened room or reading books on mathematics. He visited his girl friend quite frequently and often while shabbily dressed, and once asked her to marry him in this untidy condition. His friendship with the young lady in question broke off in August, 1941.

The parents did not definitely decide that the patient was abnormal in any way until he was charged with robbery, at which time they were able to look back and recall the abovementioned personality changes. He was brought to psychiatric hospital for observation.

During the period of observation, the patient had a normal pulse, temperature and respiratory record except following pneumoencephalography, when he ran a slight amount of fever. Behavior charts showed consistently normal behavior except for some poor appetite. He got along well with nurses and personnel and was cooperative in every way. He did, however, complain of rather frequent severe headaches and occasionally stated to the nurses that he had some difficulty in thinking. He occasionally refused food and became somewhat irritable when asked about it. Only on one occasion did he become very upset. At this time he complained of dizziness and said that things were going around and were blurred. At this time he banged his head against a wall several times and when asked about it later claimed that it seemed to make him feel better. This patient showed no evidence of psychosis nor epileptic equivalent state during his hospital stay. There is some evidence, both roentgenological and electroencephalographical that he has some degree of encephalopathy which is assumed to be post-traumatic in origin, chiefly involving the right and left parietal lobes.

Electroencephalographic studies made on this patient showed a dysrhythmia with abnormal slow waves in the right parietal region; in the left parietal lead there was rapid 18 to 22 per second diphasic spike formations. Tiny runs of normal alpha rhythm were observed in all the other leads.

CASE VII: Post-Traumatic Personality Disorder—Crowbar Personality.

R. M., 49-year-old Italian male, who was injured about two years ago by a direct blow to the forehead just above the frontal sinus. The history of the accident supports the impression that he had a severe frontal lobe trauma after





Figures 1 and 2.—Case VIII. Cerebral atrophy. Enlargement of the lateral and third cerebral ventricles, the basal cisterns and cortical pathways.

which there emerged the characteristic features of a "crowbar" personality. Along with this forebrain trauma he gradually developed a post-traumatic cataract of the right eye.

True to type the behavior since that time has been one of increased irritability, a tendency to explosive outbursts of passion, a vindictive attitude toward wife and family to the point where at times he is regarded as being homicidal.

Even today, after a month or so of hospitalization, in spite of his protestations he shows a dysphoria, an easy tearing of the eyes, tremor about the lips and other objective evidence that emotional stability is difficult for him to obtain. He is now six years in State Hospital. X-ray of skull negative.

Electroencephalographic studies revealed frequent random diphasic spikes of 80 to 120 micro volts. Occasional round topped slow waves were also observed. There was also some normal alpha rhythm in all leads but it was most prominent in the occipital leads.

IV. POST-TRAUMATIC MENTAL DETERIORATION, CHRONIC DISORDER

According to some investigators quoted by Bowman and Blau, true primary traumatic deterioration does occur. The clinical picture of this condition is very similar to that of arteriosclerotic deterioration because both have essentially the same anatomical basis, scattered widespread foci of degeneration. In the case of (F.S., Case VIII) it can be seen that the pure traumatic deterioration, the course was very rapid, the onset abrupt and directly related to the trauma and there was no systemic evidence of arteriosclerosis.

CASE VIII:

F. S., an 18-year-old boy whose tragic situation is an aftermath of severe head injury. In 1935 he was knocked unconscious in a traffic accident and was hospitalized for 26 days during which he was totally unconscious, paralyzed on the right side, and aphasic. This severe concussion improved temporarily to the point that he recovered his powers of locomotion and speech. Very insidiously he began to become morose, irresponsible, indifferent, and just before admission to this hospital became decidedly dissociated, hallucinated, with ideas of persecution, and was difficult to manage. Under observation here he shows a frank and progressive dementia. He is irritable, seclusive, manneristic, very untidy and most important of all, he is determined to inflict all sorts of injury upon his own person, notably upon his toe nails and finger nails.

He has picked away two or three of his appendages on his hands and feet, and has to be continually restrained in a jacket. His I.Q. at time of observation at City Hospital was 46. Encephalograms show the inevitable picture of brain atrophy with dilated ventricular system. He shows the following evidences of severe retrogression which offer a hopeless prognosis. For many months actively hallucinated and dissociated and the extreme autism continued without abatement. For the last several years at State Hospital he has become more quiet and definitely in an institutional adjustment stage.

CASE IX:

A. N. was a 51-year old, white, married man who had no signs of mental disturbance prior

to his injury. He was struck by an automobile on 12/27/41. He was reported apparently not unconscious at time of accident. He received emergency care at a nearby hospital and was discharged. Several days later he became quite noisy and raucous and police were called because neighbors thought he was behaving badly due to alcoholism. His condition was found to be more serious at Central Station and he was transferred to the same nearby hospital on 12/30/41. At this time he was found to have a right-sided fracture of the skull. He



Figure 3.—Case IX. Linear fracture of right parietal bone near the lambdoid suture.

became disoriented, noisy, confused and difficult to control and was transferred to psychopathic hospital on 2/5/42.

On admission he had the chief symptoms of frontal lobe disturbance for he punned easily, was grandiose and euphoric and acted much like a general paretic. Within 36 hours he became increasingly stuporous, his neck appeared somewhat stiff, his pupils were irregular at times. He also developed a spasticity of all extremities. Impression was Subdural Hematoma—right or bilateral. Surgeons were consulted and on 2/14/42 the patient had a bilateral temporal decompression under local anesthesia. Extensive lacerations of cerebrum were found bilaterally but no hematoma was found. His postoperative condition became very poor and he had a lethal exodus 9 A.M., 2/15/42, about six weeks after accident. This patient was followed to autopsy and a complete pathological study is presented at end of the discussion.

CASE X:

J. A., a 43-year-old man who comes in with signs which are consistent with the story of severe head injury with intracranial complications. Some two weeks before admission he was involved in a melee or injured by falling.

On admission spinal fluid was xanthochromic and showed a positive benzidine reaction. The X-ray clearly outlines a fracture through the entire left side of the vault of the skull. These two objective findings coupled with the subjective components of headache, confusion, and of frequent dissociation establishes the diagnosis of traumatic encephalopathy.

The patient did not show a vivid confusion here, but was rather depressed, apathetic, and abulic. He has gradually improved in his subjective state, but the patient after the 90-day observation period is inclined to impress us with the fact that he still has the characteristic symptoms of post-traumatic head syndrome, particularly dizziness and headache.

It is quite likely that these symptoms are being amplified because the patient has practically no place to go and the hospital routine is decidedly comfortable.

In a staff conference on December 23 it was pointed out that this man had considerable intracranial trauma, but that topically he seemed to be improving. It was also suggested that he may be malingering to prolong his stay in the hospital, having the peculiar characteristics of a Mexican. Subsequent objective data reveals that his psychosis is becoming amplified into a typically dissociation, confusional and hallucinated state. It appears, therefore that we must classify him as a severe post-traumatic encephalopathy. He may be an old schizophrene in whom trauma precipitated this full bloom dissociated state.

V. OTHER TYPES--WITH EPILEPSY, CONVULSIONS

POST-TRAUMATIC CONVULSIVE STATE

Elvidge[7] states that an epileptic seizure may occur at any time after a head injury and for purposes of discussion he divided the cases of post-traumatic convulsive states into those which occur in first 12 to 24 hours of the injury, those that occur in the convalescent period (two to

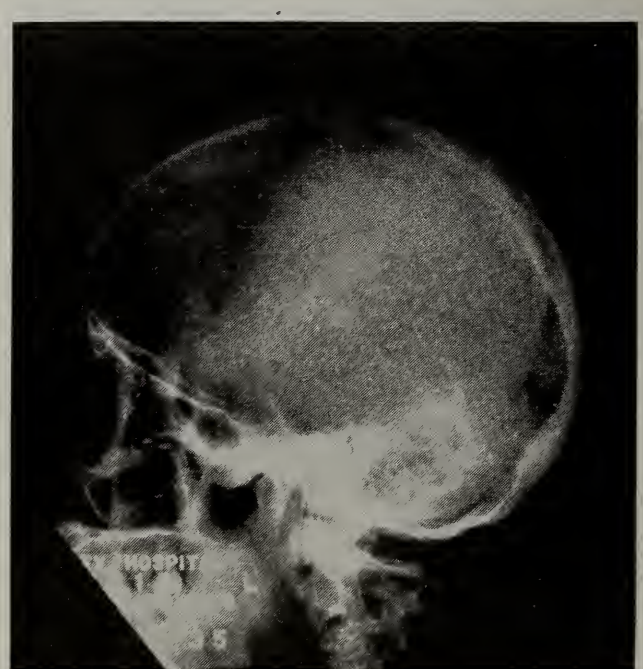


Figure 4.—Case X. Linear fracture of left parietal bone.

four weeks after trauma) and those which occur after the patient's apparent recovery from the injury. In a series of 60 cases studied by B. Penfield,[8] 34 were caused by meningo-cerebral or cerebral cicatrix; two cases of arterio-venous aneurysm; one was a gun shot wound; and eight were miscellaneous cases.

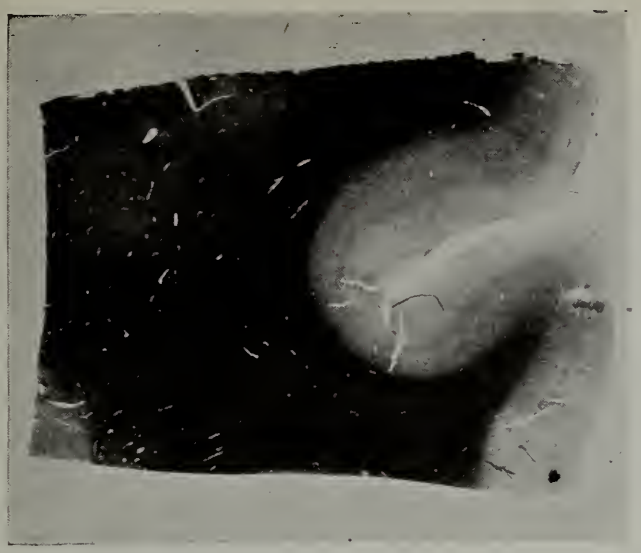


Figure 6.—Case X. Section from the right frontal lobe caudal to the area of injury and shows demyelinazation of white matter, probably secondary to cortical damage and possibly to focal anoxia.

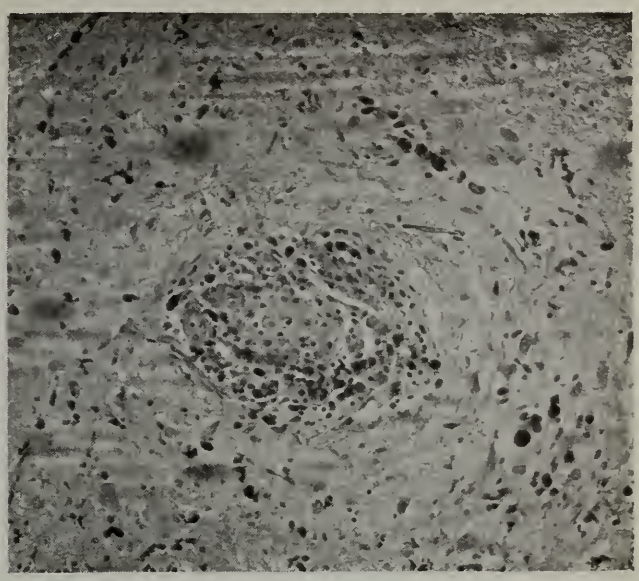


Figure 7.—Case X. Section from the base of the pons—a remote petechiae—shows an occlusion of a small vessel with perivascular hemosiderosis degeneration and gliosis, evidence of remote injury in the surrounding brain tissue.

CASE XI: Encephalopathy with Epilepsy.

P. G., a patient 25 years of age. He is a male nurse by occupation. Approximately one year ago it is said that he was in an automobile accident when he had multiple bone fractures and among other things a serious head trauma. Several months ago while in Cleveland he developed symptoms which led the physicians at the Cleveland Clinic to suspect subdural hematoma. At that time there were focalizing symptoms referring to the right cerebral hemisphere. A double trephine was done over the parietal area, but no pathology was detected.

It is said that the patient's basic temperament is somewhat unstable, that he has had great difficulty in adjusting himself and among other things, there is a story of marital disaster. He is divorced from his wife. Just before his admission, his roommate and friend was reading a letter from the wife for the patient. During the recital the patient suddenly became comatose, and there was a clonic spasm of both lower extremities. In this condition he was readmitted to the Cleveland Clinic. There it was found that he was maudlin, noisy and confused as if he were in a post-epileptic furor.

We are not certain whether he had a genuine grand mal seizure, although we must concede that that was a possibility. There is also the likelihood that the episode was a major hysteria.

We cannot deny that when the patient was admitted to this institution he was somewhat clouded but rapidly improved and claimed an amnesia over the entire period of excitement. Neither can we deny that there are organic features in this condition. As was noted by the staff members of the Cleveland Clinic, the patient still shows residuals indicating an organic defect in the right hemisphere. There is a hyper-reflexia over the left side. The left lower facial mechanism is still weak, and the patient claims a weakness of the extremities on the left side. Both abdominals are absent.

Intermittently and particularly when excited or made self-conscious, the patient shows a rigor and clonic excitement of the left lower extremity.

Electroencephalographic studies of this patient showed a marked dysrhythmia from the right cortex. There are frequent high voltage diphasic spike occurring singly and in short runs. There are also slow waves in the right parietal region. Record from the left side is within normal limits.

POST-TRAUMATIC PERSONALITY DISORDER

CASE XII:

R. M. is now 25 years of age. When he was 12 years old his brain was so traumatized that there was immediate traumatic coma extending over a month and a confusional state which obtained for nearly a year. Furthermore, it is stated that for nearly two years after the trauma, he had intermittent attacks of grand mal.

His behavior, particularly during his adolescence and early adult life was in keeping with the concept of a profound degree of under development and traumatic disintegration. His whole record shows a pronounced instability, a consistently infantile and narcissistic behavior, a loss of judgment and a persistent trends towards antisocial behavior. On two occasions he has been arrested for peeping into people's bedrooms. The longitudinal history further shows that he has been unable to adapt himself very consistently to any type of work.

Very likely the reason that he has not been in trouble before is because he has been guarded and sheltered by parents and relatives who have become intuitively aware of his deficiencies. The police finally insisted that something be done.

On the ward his behavior is distinctly that of a hypophrenic individual whose capacity to gain from experience and whose ability to adjust himself easily to other people is decidedly inadequate. His psychological testing shows an impulsive and unstable temperament and a definite defect in the higher tests for judgment and discrimination. He is incompatible with a normal social environment and is a state patient because he is a social menace.

The electroencephalogram shows frequent random and multiple high voltage spikes in all leads.

GROSS DESCRIPTION OF BRAIN AND MENINGES

The following are the pathological characteristics which were found in the traumatized brain of CASE IX.

"There is a defect in the lateral aspect of the dura mater on both sides of the brain. This defect measures 2.5x2.0 cm. in diameter and corresponds to the site of the overlying trephine defect of the skull. There is no extradural hemorrhage. No subdural fluid is noted. A small amount of fresh subdural hemorrhage can be seen over the left cerebral hemisphere" (Dr. Reuben Straus).

The brain and leptomeninges weigh 1590 gm. The gyri are flattened, the sulic narrowed. Dura is bound by readily torn fibrous bands to arachnoid over an area of approximately 4.0x4.0 cm. in the region of the medial portions of the orbital aspect of the rostral part of the frontal lobes and the frontal poles of the frontal lobes. Partial reflection of this dura shows a delicate fibrous layer on its internal aspect containing patches of rust-colored pigment and small dark purple foci. The underlying piarachnoid is thickened, gray, semi-opaque and patchily discolored rust-brown. In this area pia and arachnoid are more firmly adherent than usual. Portions of it lift away easily from the brain substance, revealing irregular lacerations of cortex of orbital and straight gyri of both sides. There is rust-brown discoloration of the lacerated cortex. The olfactory bulbs and rostral portions of the olfactory tracts cannot be identified. Similar leptomeningeal and cortical lesions, approximately 2.0 cm. in diameter, are present on both sides bridging the Sylvian fissure to involve the caudal portion of the orbital gyri and the rostral end of the temporal lobe.

There are recent subarachnoid hemorrhage, laceration of cortex, and cortical and subcortical petechiae in each opercular region, involving areas 5.0x5.0 cm. on the left. These correspond in position to the dural and skull defects previously described.

The leptomeninges are gray and semi-opaque over the vestex along the longitudinal cerebral fissure. There are small patches of rust-brown discoloration of pia-arachnoid in the left pre-occipital sulcus, right pre-central gyrus and right post-central gyrus.

Multiple frontal sections of the cerebral hemispheres and diencephalon show recent hemorrhage in the following places: right lenticular nucleus, rostral part, 1.3x1.0x1.0 cm.; right thalamus, lateral nucleus, 0.7x.0.6x0.3 cm.; and smaller hemorrhages in the cortex and subcortical white matter of the opecular regions. Numerous foci of remote infarction, cystic spaces traversed and lined by delicate gray tissue, up to 1.0 cm. in greatest diameter, are seen in both lenticular nuclei; right thalamus and base of the pons. Rust-colored spots up to 0.2 cm. in maximum diameter, are seen in various portions of the pons, brachia pontis, dentate nuclei and white matter of cerebellum.

Ventricles and choroid plexses are not remarkable. The right posterior communication artery is uncommonly small. Portions of the major cerebral vessels, which are ectatic, have yellow-gray, opaque, slightly thickened walls. Neither thrombi nor emboli are seen.

DIAGNOSES:

Linear Fracture—chiefly through parietal bone.
Old subdura hematoma, subfrontal.
Dura-arachnoid adhesions, subfrontal.
Recent craniotomy, temporal, bilateral, with local subarachnoid hemorrhage and contusion of brain.
Edema of brain.
Recent hemorrhage in right lenticular nucleus and thalamus.
Remote infarcts, right and left lenticular nuclei, right thalamus and pons. (Remote Petechiae.)
Cerebral arterial sclerosis, moderate.

MICROSCOPIC DESCRIPTION

Sections of the straight gyri with attached meninges show fibrous and granulation tissue on the internal surface of the dura, binding dura to arachnoid and uniting arachnoid and pia. Macrophages crowded with granules of yellow-brown pigment, which gives a positive Trumbell blue reaction, are numerous in these structures. There is partial loss of cortex, with numerous gitter-cells and pigment containing macrophages in the defect. The bordering brain tissue is the site of cellular and fibrillar gliosis and focal pigmentation. Small foci of degeneration and pigmentation occur remote from the main lesion. Perivascular edema is evident. There is a small mass of calcified tissue near the contusion. Myelin sheath stains show small to large areas of partial to almost complete demyelinization. Medium and small arteries are the site of internal sclerosis.

Sections of the right and left opercular areas show recent subarachnoid hemorrhage, partial disruption of cortex and cortical and subcortical petechiae. No material giving a positive Trumbell blue reaction is present.

Sections from the right lenticular nucleus and thalamus show recent hemorrhage and remote infarction; from right brachium pontis and adjoining pons, foci of gliosis and pigment-containing cells which give a positive Trumbell blue reaction. A remote infarct is seen in the base of the pons.

Sections of several frontal and temporal gyri show slight fibrosis of the pia-arachnoid, occasional cells with pigment giving a positive Trumbell blue reaction, rare slight perivascular infiltration of small round cells in the cortex, and peri-vascular edema. Small to medium arteries are involved by intimal sclerosis.

CONCLUSIONS

This study was undertaken to see if there were any individuals who developed psychoses due to head trauma. Representative cases are presented which were classified according to the standard classified nomenclature of diseases under the heading, Mental Disorders, the group Psychoses due to trauma. We believe that such a discourse serves to impress one with the immensity of the problems which might come in the wake of the head injury.

ACKNOWLEDGMENT

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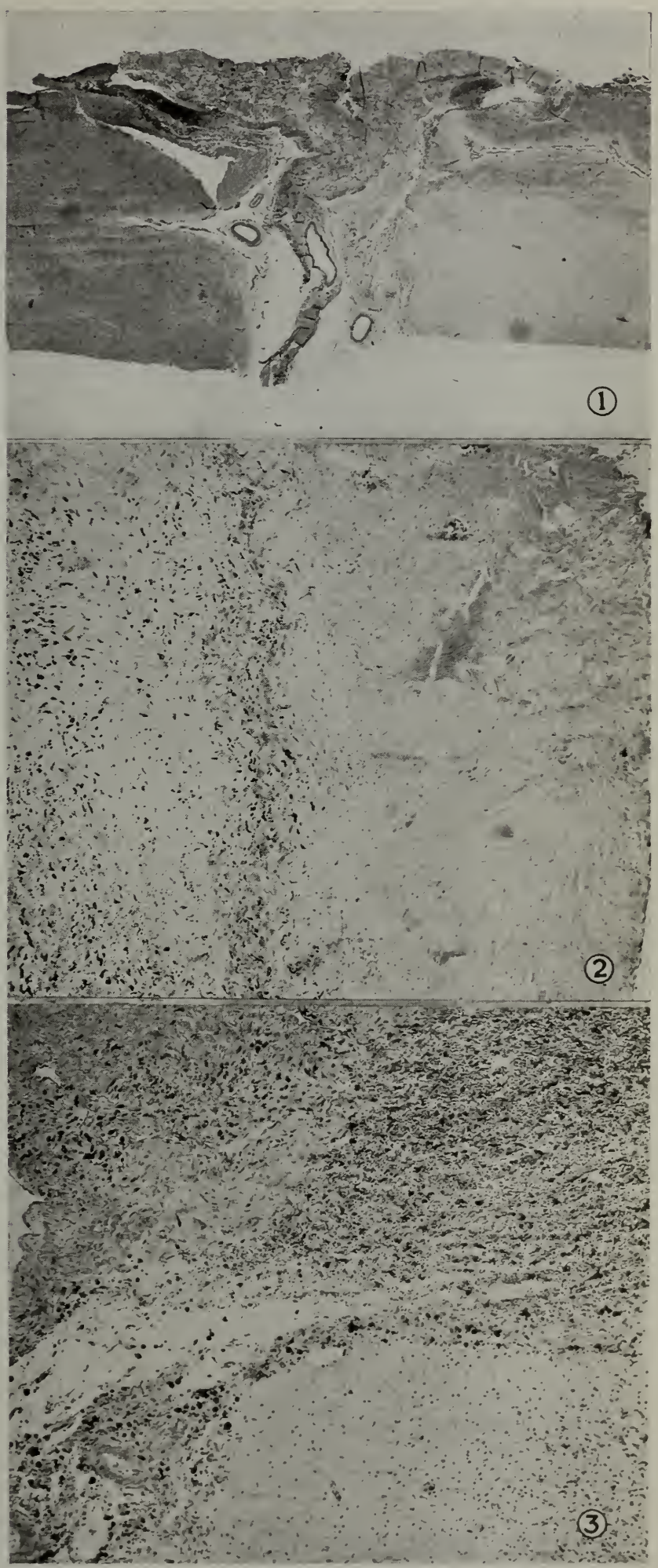


Figure 5.—Case IX.

I. Section: Through orbital and straight gyri of both frontal lobes, including meninges and falx. This section shows contusions and hematoma. Shows adhesion of dura and arachnoid (new membrane). These are evidences of remote injury.

II & III. Sections: High magnification of first slide.

II. Shows dura and subdural hematoma. Evidence that it is a remote injury is seen by presence of the fibrosis, vascularization and numerous phagocytes with hemosiderin therein.

III. Shows the rest of the subdural hematoma fused with the arachnoid and more laterally there is loss of cortex with hematoma in the defect and focal degeneration in the cortex.

Studies in Human Inheritance XXIV. Bridged Sella As A Genetic Trait

LAURENCE H. SNYDER, Sc.D., and FRITZ BLANK, M.D.

UNION between the anterior and posterior clinoid processes of the sella turcica with occasional inclusion of the middle clinoid occurs, as Camp (1926) has pointed out, in about 5 per cent of necropsy specimens. This anatomic variation is commonly referred to as "bridged sella" or, as LeWald (1926) in his discussion of Camp's paper suggests, as "closed sella", since the processes are not always fused, but may only closely approximate each other.

The present authors have undertaken by means of X-rays of family groups a study of the possible genetic nature of variations in mastoid cells, configuration of the sinuses, and size and shape of the sella turcica. In the course of this investigation a family was encountered in which bridged sella occurred in five members of three generations. It is the purpose of this paper to report and discuss the family history.

The pedigree appears in Figure 1. An X-ray photograph appears in Figure 2. With the exception of the picture of I, 2, all photographs were taken in the X-ray room of St. Francis Hospital, Columbus, Ohio, using the standard position for sella pictures. The grandmother (1, 2) lived in Lima, Ohio, and had to be X-rayed there. The bridged sella appears to be due to a simple dominant factor. It may be added that the five cases in this one family were the only instances of bridged sella encountered in 125 individuals so far studied in family groups.

There is some difference of opinion as to the anatomical substratum of the bridged sella. While Wieser (1925) assumed that the bony structures forming a sella bridge are caused by inflammatory processes with subsequent bone (spur) formation, Goldhamer and Schueller (1925) in their investigation on varieties of the sella turcica reached the conclusion that a sella bridge is a true variety, originating from preformed extrasellar ligaments of the dura mater which in cases of bridge formation become bony structures. Most authors (e.g, Schneider 1939) agree with this explanation, although there is little agreement on its pathological importance.

THE BRIDGED SELLA

Whereas LeWald believes that a bridged sella may cause "an element of pressure on the pituitary gland, that is to say as the gland is congested and circulatory changes are taking place

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so-called pituitary headache will result if there is not allowance for expansion laterally", Camp states that its occasional presence, in patients showing endocrine disorders is merely a coincidence and that the anatomic variation is of no clinical significance. Goldhamer and Schueller feel that there is no proof that the neighboring soft tissue structures are interfered with by this bone formation.

Goldzieher (1939) states that a bridged sella practically closed, or a small and abnormally shaped sella, is frequently seen in persons suffering from migraine. In a personal communication to one of us (F.B.) he states that "although these changes (bridged sella) may occur at times without symptoms, a definite symptom complex is almost regularly associated with this type of sella anomaly. The projecting clinoids or osseous bridges over the sella have a tendency to press upon the stalk of the pituitary gland and interfere with the function of the posterior lobe. The result is sodium chloride and, usually, water retention; this may or may not be associated with obesity. The most common symptom of salt and water retention is headache, usually of the migraine type. In other patients, the salt and water retention affects primarily the skin or mucous membranes, and the symptoms are angioneurotic edema, hives or various other so-called allergic manifestations which, as a matter of fact, are refractory to the conventional ministration of the allergist. Epileptiform seizures are other rarer manifestations of the same basic chemical disorder . . . If the sella is very small in addition to the overbridging, short stature and genital hypoplasia may be noticeable as an indication that the development of the anterior lobe was also interfered with."

IMPORTANT CLUE

This concept, if correct, may give us a clue to an understanding not only of the conditions men-

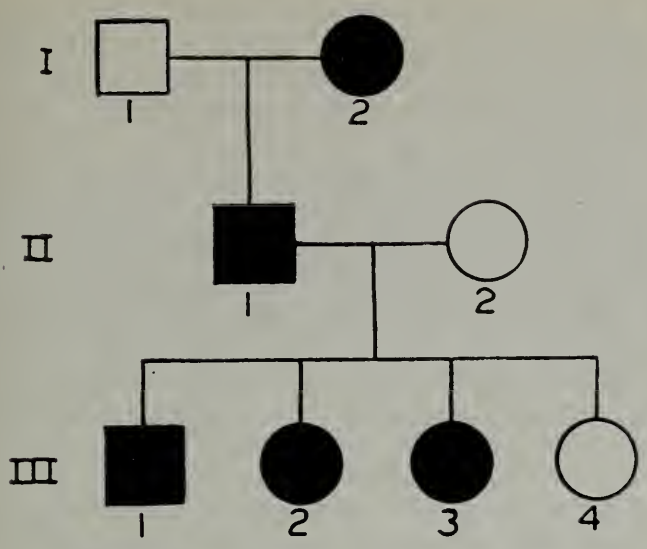


Fig. 1. Pedigree of a family in which five members in three generations had bridged sellas.



Fig. 2. Bridged sellas as it appeared in the family reported here. The pictures were similar in all the affected members.

tioned, but also to certain differences in body stature as reported by Ratner (1927). Ratner pointed out the fact that bridged sella is found in a much higher percentage of individuals of "pyknic" body constitution than in those of "asthenic" type. He further stated that the bridge formation itself is not incidental, but that it is the expression of a constitutionally determined "Unterwertigkeit" (inferiority) of the hypophysis-diencephalon system. As evidence for this view, he presents a family in which the Lawrence-Moon-Biedl syndrome was inherited through three generations, each affected member of which upon X-ray examination showed a bridged sella.

Schneider, while rejecting Ratner's concept of a "diencephalose" of which bridged sella is one sign, is nevertheless convinced that a closed sella is correlated with an "Unterwertigkeit" of the bone system, but, rather than being the symptom of a disease, it is the sign of a constitutionally determined weakness which may predispose to certain diseases. In the families of his 25 patients with bridged sellas there was always evidence of hereditary metabolic or nervous disturbances, and the patients themselves showed similarities in their constitutional aspects as well as in their complaints. In several of the families similarities of sella shape among the various members was mentioned.

Dillon and Gourevitch (1936) studied the shape and dimensions of the sella turcica in 26 pairs of twins, 12 pairs being identical twins and 14 pairs fraternal. Nine of the identical pairs showed "considerable similarity", while 3 pairs showed "small differences". On the other hand, only 4 of the fraternal pairs showed considerable similarity, 6 pairs showed small differences, and 4 pairs showed great differences.

Aside from these few instances almost nothing is found in the literature on the genetic nature of sella shape, and this in spite of many reports on the relationship of bridged sella to constitutional traits. It is hoped that the present investigation may throw light not only on bridged sella, but also on normal sella configuration, from the genetic standpoint. Meanwhile the single family thus far encountered with bridged sellas is presented here.

THE FATHER

Only in the father (II, 1) have there been found certain symptoms which according to the statements of Goldzieher and others might be correlated with sella bridge formation. The father had migraine headaches beginning at the age of 13, recurring approximately once a week, unrelieved by sedative or headache medication, associated with visual disturbances, nausea and vomiting, and usually lasting during the day of onset until the next morning. However, at about the age of 40 these headaches ceased and there have been no recurrences during the past 10 years. There is a history of allergic reaction to poison oak, bee stings and mosquito bites. When, on the occasion of a minor trauma, X-ray pictures of the left elbow were taken, it was discovered that there was a congenital malformation consisting of an extremely shallow socket which was found to be repeated in pattern on the right elbow. There are no other skeletal deformities, and otherwise this individual has been normal and healthy in every way.

No other member of the family has ever complained of the type of headaches experienced by the father. There is no history of epilepsy or convulsions in the family, and there has been no clinical evidence of water imbalance, such as edema or polyuria. No angioneurotic edema and no suggestion of any endocrine abnormality present themselves. The secondary sex character-

istics have developed normally and there has been in the female members of the family a normal onset as well as a normal cycle of menstruation.

In the mother (II, 2) and one daughter (III, 4) neither of whom showed a bridged sella, there were markedly elongated processes clinoidei anteriores. Moreover, the round shape of the sella of the mother is repeated in this daughter.

SUMMARY

In contrast to the 5 per cent incidence of bridged sella in the general population, a family is presented in which this condition appeared in five members of three generations. The bridged sella appears to be inherited on the basis of a dominant factor. None of the symptoms sometimes associated with bridged sella was found in this family, with the exception of migraine headaches and a minor bone anomaly in the father.

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Functional Uterine Bleeding

Besides the old standbys among conservative methods of treatment, such as administration of thyroid, calcium, iron, ergotrate, bed rest, and so on, more effective methods of conservative treatment for functional uterine bleeding have been developed in recent years.

Hamblen and associates have shown that functional bleeding can be controlled by giving cyclic injections of stilbestrol or natural estrogens and progesterone, to correspond somewhat with the natural balance between estrogen and progesterone. Bleeding also can be controlled occasionally by administering enough progesterone to produce a secretory endometrium. Chorionic gonadotropin has been administered with the same idea in mind, to obtain a secretory endometrium, since most functional bleeding occurs in the presence of the proliferative phase of endometrium; serum of pregnant women can be used also for the same purpose. The difficulty with these forms of treatment is that they are merely palliative procedures and must be continued over a more or less prolonged period. And, of course, no hormonal treatment should be given until the physician is relatively sure that there is no malignant disease present.

Recently considerable attention has been given to the use of the male hormone as a method of treatment of functional bleeding. Huffman found his best results with doses of from 30 to 50 mg. weekly. He assumed that cessation of genital activity is due to inhibition of the pituitary rather than to ovarian suppression. Testosterone propionate can be given subcutaneously or methyl testosterone can be administered by mouth. The disadvantages, according to Huffman, are that the testosterone is likely to cause masculining phenomena, especially if the dosage exceeds 200 mg. a month; the treatment is not curative, but merely palliative.

Since the advent of stilbestrol and more potent natural estrogens a new type of bleeding is being seen, namely, that induced by administration and withdrawal of estrogens. For women who are experiencing the vasomotor waves, tension, anxiety, insomnia and so on, that are sometimes concomitant with cessation of menstruation, oral or parenteral administration of an estrogenic substance is the accepted treatment. Use of stilbestrol or other estrogenic hormone in large doses over a short time may cause vaginal bleeding which may not occur until discontinuance of the medication, the "withdrawal bleeding" syndrome. When a woman who has not menstruated for six or more months begins to bleed again, the symptoms must not be disregarded. Occasionally it becomes necessary to do a diagnostic curettage to rule out the possibility of malignancy of the fundus, even though the physician may be relatively certain that the bleeding is the result of administration of the estrogenic hormone.

A review of 200 cases should give a good sampling of the condition under scrutiny. In the series of cases reviewed for this study relatively atypical proportions were found of the following: (1) Minor benign conditions causing abnormal uterine bleeding (2) more severe benign conditions requiring hysterectomy or irradiation and (3) carcinoma of the uterus. In an average office practice one should encounter a much larger proportion of minor conditions proportionally fewer cases of fibromyoma and a still smaller proportion of malignant lesions. This discrepancy probably is an outcome of the tendency of sick people not to undertake a more or less tedious trip for medical care at some expense, unless their symptoms have become aggravated enough to cause them grave concern about their illness.—Robert D. Mussey, M.D., and Thomas R. Wilson,. M.D., Rochester, Minn.; Jour. Michigan State Med. Soc.; Vol. 43, No. 2, February, 1944.

What the Army Chest Survey Means to the Civilian Doctor

ROY H. THOMPSON, M.D.

THE chest surveys conducted on the present large scale are a definite index of the national health of a considerable portion of the human body. Chest films serve the individual and serve society by identifying many chest diseases. At this time we are concerned principally with tuberculosis.

It may be well at this point for us to review briefly some of its pathogenesis applicable to the X-ray in the terminology of Army Regulations. Most tuberculous infection occurs when the bacilli are inhaled into the alveoli near the lung periphery. They are then phagocytized by neutrophiles. In three to seven weeks the tissue becomes sensitized to the protein fraction of the tubercle bacillus. This lasts as long as the bacilli. Sometimes if completely encased in calcium the bacilli may live and the body lose its sensitization. Some bacilli invade the lymphatics and reach the hilus nodes. This is the primary complex. Most cases heal at this point. The bacilli may then travel through the thoracic duct and enter the innominate vein. This takes them through the right heart and pulmonary arteries to the lungs again where the process recurs. A particularly vulnerable area is the apex. The bacilli may go on through the lungs into the systemic circulation to form lesions in other organs. This is called lymphohematogenous dissemination.[1]

Chronic forms may remain latent for months or years. If extrapulmonary ulceration finally occurs, the bacilli may again find their way to the lungs. Endogenous or exogenous reinfection usually begins to be seen in late adolescence. If pulmonary ulceration results bacilli escape and spread into contiguous and distant alveoli. At this point the X-ray picture is usually that of a small patch of exudative tuberculous lobular pneumonia. This is unstable for as long as several years. Enough evidence has been gathered both from human autopsy studies and from cattle to assume that all reactors to the tuberculin test have tuberculosis some place in their bodies even though the focus may be only microscopic.[2] This includes about 20 per cent of the population. About 10 per cent of these show positive X-ray findings.

Some of those rejected for lesions characteristic of tuberculosis will not have this disease. Chest conditions simulating it accounted for 6 per cent of 1,736 admisisons at the Minnesota State Sanatorium.[3] This agrees with the work of the New York City Department of Health. They made a complete chest study of 94 per cent of the Army rejectees in New York City. They could only recertify 8 per cent of the original rejections.[4]

The Author

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CHEST FILMS

X-ray films including chest films will be a great aid in the settlement of future claims. Both the individual and the army will be protected. However, in spite of all our precautions Wolford[5] states that 100 men per month are now being hospitalized in Veteran's Hospitals for tuberculosis. This may be explained to some extent by the fact that regular army enlistments were largely accepted without X-rays prior to and during 1940 and 1941 and part of 1942. Kinsey[6], in a review of 1,000 cases receiving Certificate of Disability Discharges, found that tuberculosis accounted for 1.7 per cent of these. The rejection rate for tuberculosis during the last war was .7 per cent. This was too low and has cost the Federal Government over $1,000,000,000 in compensation. Metropolitian Insurance Company statistics show that tuberculosis mortality among policyholders during World War I was five times the current figure.[7] An estimate based on the present rejection rate shows that we will surely salvage about 75,000 men who have early active tuberculous lesions if a proper follow-up is done by the local civilian doctor, including adequate early treatment.

Further, the number of exposure cases resulting from accepting these men into the armed forces is definitely reduced. Pope and Twinan[8] over two years' time laboriously traced four advanced cases in a small community to a minister's wife whose disease was unrecognized until she left the community. The cases occurred in girls between 15 and 20 years of age who had only weekly or bi-weekly contacts. Seidemen[9] studied 479 households containing at least one tuberculous person and found a morbidity of 7 per cent in contacts. He gives a six-year fatality rate of 5 per cent for minimal cases. This is the type we are attempting to keep out. An observation on evacuated children in England either bivouacing

Opinions expressed here are those of the author alone. Read before the meeting of the Franklin County Tuberculosis Association on October 20, 1943.

or attending schools together was made by Hall.[10] He found that one child had infected six others and another infected nine.

Judging from occasional telegrams and letters from various army units after induction, it is obvious that a certain definite though very small percentage of minimal tuberculosis is missed. This is due to two factors. One is technical faults of the film hiding the pathology. The other is fatigue. We use only 14x17 films. Many days it has been necessary for the author to read over 300 chest films. This is in addition to the other work which normally occurs in a 250-bed hospital. These factors are also true in inductions stations but the latter is being corrected as more medical officers are trained.

TABLE I

	Physicians	Dentists	Total	Other Civilian	Total No. of Cases*	Rejection (%) TBC Incl. 6 mo. rechecks
Kellogg			24.2	6.	2046	4.
Author	42.7	44.6	43.6	19.8	977	5.

Table showing comparison of rejection rates of two separate Officers' Examining Boards.
*All figures except these represent percentage.

ARMY REQUIREMENTS

Army regulations are written not only to exclude present active disease including tuberculosis but also to exclude those cases of possible future clinical significance. In 1940, the Division of Medical Sciences, National Research Council[11] concluded that at least 75 per cent of early active pulmonary tuberculosis can be discovered by X-ray examination and about 1 per cent of the male population of military age has active tuberculosis, most of which can be detected only by X-ray. They also felt that a high percentage of these cases is likely to break down under the strain of exposure to military duty.

Tuberculosis ranked seventh in man-days lost during the last war. In Canada a recent report of the Institute of Pensions states that 23 per cent of the deaths from disease in veterans of World War I were due to tuberculosis. These men averaged two years in the hospital. The cost per case averaged $12,000. Koch's phenomenon, as we know, shows that a much greater tendency to breaking down exists in the reinfection type of tuberculosis than in the primary type. DeLorimer[13] has found that in the military age group 30 per cent of the reinfection type cases require further hospitalization while this is true of only 4 per cent of the primary cases.

In a recent study Bloch[12] has shown that the average time of calcification of a Ghon tubercle is six to eight years in the adult and is much faster in children. Reinfection cases calcify much more quickly. If the original focus cleared leaving no trace, a reinfection tubercle could occur in the child or in the adult. Therefore, the Ghon could be evidence of primary or reinfection tuberculosis and should no longer be connected with childhood. This could explain why we have seen some adult cases calcify within a year.

Mass X-ray surveys in the armed forces have been made in various ways. The army has proven to its satisfaction[13,14] that the 4x10 stereo photofluorograph is the best. It combines two views for comparison, is easily read, and accurate as to trust. Its cost is conservative, about 12 cents, and it is speedy enough as up to seven per minute can be taken.

Some interesting observations were made by Kellogg[15] who is assigned to an examining board similar to ours. His results are summarized in Table I and compared to a small sample survey of our own cases. His rejection rate for physicians and dentists was four times as high as his rate for other civilians. Ours was doubled. Kellogg's average over-all rejection rate was 24.2 per cent for physicians and dentists while ours was 43.6 per cent. Kellogg's rejection rate for all groups because of tuberculosis was 4 per cent as compared to ours of 5 per cent.

In order to arrive at some definite opinion as to the relative value of our own statistics and for use as a basis of comparison Table II was compiled from some of the recent literature on mass chest surveys. A total of 3,036,036 cases collected from the literature were grouped so as to fit in approximately with the army grouping. The various percentages were then averaged to give figures of .42 per cent apparently active, 1.29 per cent apparently inactive, and 3.06 per cent total of cases considered of possible future clinical significance.

A detailed study of specific groups was made from our findings which is presented in Table III. This table compares the variation in the rejection rate for tuberculosis prior to the change in M.R. 1-9 which was 2.1 per cent as compared to the rate after this change or 1.66 per cent. The films were read by the same personnel making an exact comparison justified. On the same basis

TABLE II

No. of Cases	Source of Survey	Films Considered of Possible Clinical Significance		
		Per cent Apparently Active	Per cent Apparently Inactive	Total
10,000	Levitin: (16) Army Induction Board	.65	.65	1.30
558,075	Lees: (17) College Students	.13		
75,000	Evans: (18) W.A.A.F. and Airmen	.34		
247,257	Duncan: (19) Naval Recruits	.12	.32	.44
270,060	Mason: Great Lakes Naval Recruits			7.00
1,850,000	Lyght: (20) College Students	.20		
15,644	Edwards: (21) Factory workers	.61	2.92	3.53
10,000	Brown: (22) Army Inductees	.92		
3,036,036	Average total per cent	.42	1.29	3.06

applicants for the Women's Army Auxiliary Corps showed a higher rejection rate than the male enlistments or 2 per cent. Army Nurse Corps applicants show the rather startling rejection rate of 4.87 per cent. The conditions of the examination were similar in all cases as the regulations pertaining to officers and enlisted men have been made fairly uniform regarding the chest X-ray examination for tuberculosis. The table represents a random selection of approximately the same age groups.

The Division of States Relations, Washington, D. C., Tuberculosis Control Section, places mass X-ray facilities at the disposal of industry to show them what can be done. Hilleboe,[23] who has charge of this program, also advises using the Armed Forces case finding program more fully. As an example of how the former plan works we may observe the set-up which has already been under way for over a month in Cleveland, Ohio. The U. S. Public Health Service is examining 100,000 workers in defense plants. A rate of 120 exposures per hour is expected. The 35 mm. film photofluorographic unit is used. Regarding the latter statement, local cooperation is necessary for success of case finding measures. The induction boards send their "rejected" list to the Selective Service Headquarters which, in turn, sends each county a list of the men rejected in their county. The rest is up to the civilian physician. Our Officers' Examining Board has recently started the policy of notifying local county health officers of all questionable or active cases found.

Very meager statistics showing the relative prevalence of tuberculosis in the white and negro groups are available. Few cases have come through our clinic. Rowntree et al.[24] gives an interesting comparison of white and negro 18 and 19 year old selective service registrants. The over-all rejection rate among whites was 23.8 per cent while the negro rate was 45.5 per cent. Rejections for tuberculosis were .66 per cent in the white race and .97 per cent in the negro in samples of 45,000 cases.

TABLE III

No. of Cases	Source of Survey Regulations changed Oct. 15, 1942*	Rejection Per Cent Incl. 6 mo. rechecks
13,000	Male enlisted applicants Oct. 1940-Jan. 1942	2.1
7,789	Male enlisted applicants Nov. 1942-Sept. 1943	1.66
3,970	WAAC applicants Nov. 1942-Sept. 1943	2.
246	ANC applicants Nov. 1942-Sept. 1943	4.87

Table showing comparison of various groups

*The above change refers to the acceptance of previously rejected small fibroid lesions represented in the films as sharply demarcated strandlike or well-defined, small, nodular shadows not exceeding a total area of 5 square centimeters provided stability is certain after an observation period of six months.

The battle with tuberculosis should suffer a set-back in direct proportion to the length of the war. We should expect an increase in the immediate future. Recent statistics show the death rate from tuberculosis in Yugoslavia in 1937 was 189 per 100,000.[25] In New Zealand in 1939 the death rate was 337 per 100,000.[26] This is in con-

trast to our own record in the United States of a decrease from 47.9 per 100,000 in 1938 to 43 per 100,000 in 1942.[27]

The final act of the armed forces in the battle against tuberculosis is the X-ray examination of its personnel upon their discharge.

CONCLUSIONS

1. The armed forces are conducting a tuberculosis survey both male and female on a scale never before conceived. This, in addition to the ever-growing industrial surveys, reaches a large percentage of our population in the age group most vulnerable.

2. We must not waste this opportunity in our attempt to stamp out a disease which particularly affects the financial group most likely to become a burden on the community. This means adequate follow-up treatment and education of the patient.

3. The high incidence of tuberculosis in some of the warring nations plus poor living conditions there will have an unfavorable effect upon our own pregressively diminishing rate. Our big opportunity to combat this will be the final chest examination of military personnel upon their discharge.

4. There is a higher incidence of tuberculosis—(a) in women than in men; (b) in older age groups; (c) in the negro than in the white.

5. Rejections by the army for clinically significant tuberculosis are based on sound medical opinion. Further studies prove justification for the rejections to a satisfactory degree.

6. Physicians, dentists, and nurses who are tuberculosis contacts should obtain a routine yearly check-up including an X-ray film of the chest lest they spread the very disease we are combating.

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Paracentesis of the Anterior Chamber

Paracenteses are done generally for one of the following three purposes:

1. To remove undesirable material from the anterior chamber.

2. To lower intra-ocular pressure temporarily.

3. To remove the blood-acqueous barrier temporarily.

Very little has to be said about point 1. Few hemorrhages into the anterior chamber have to be removed surgically. An important lesson in my life has been the distinction between stubbornly persistent and recurrent hemorrhages. The latter obviously do not call for surgical removal. Hemorrahages are persistent if the iris is very atrophic, covered by a homogeneous membrane or entirely absent. The absorption of hyphemas is then either very slow or an impossibility, making surgical interference nesessary. Another indication for surgical removal of a hyphema is persistent elevation of intra-ocular pressure during the first few days following a severe contusion of the eyeball.

Among the foreign bodies which may be carried into the anterior chamber during injuries or operations, there are a few which, because of their chemical inertness, do not have to be removed. Such substances are droplets of petrolatum or cotton fibers, which are not infrequently found in the anterior chamber after the cataract operations which have entailed irrigation of the anterior chamber.—Peter C. Kronfeld, M.D., Chicago, Ill.; Jour. Ind. State Med. Assn., Vol. 37, No. 3, March, 1944.

Acute Gangrenous Appendicitis Complicated By Pylephlebitis*

OLIVER EITZEN, M.D.

Case History. J.S., white male, 42 years of age, was brought to University Hospitals on October 9, 1943, for penicillin treatment because of septicemia. The patient had been operated on at another hospital for acute gangrenous appendicitis one month previously. After the third postoperative day the patient had a daily rise in temperature (to 40° C.) for which he was given sulfathiazole, to which he was "very intolerant". He was also given transfusions and hemo-irradiation. Two and one-half weeks later, an exploratory laparotomy was performed because of a suspected subdiaphragmatic abscess. None was present and no other lesions in the abdomen were noted. Five days later a positive blood culture (Streptococcus haemolyticus) was obtained. On admission the patient was seriously ill, with a temperature of 40.3° C. and a pulse rate of 120. There was 2+ albuminuria. Urinary sediment contained occasional Wbc and many Rbc per high power field. The red blood cell count was 3,660,000 and the white blood cell count varied from 5,250 to 9,900 per cubic millimeter. On admission the prothrombin content was 6.5 per cent of normal but with vitamin K administration it rose to 80 per cent of normal. The BUN was 46.5 mg./100 cc. and the creatinine 1.8 mg./100 cc. The CO_2 combining power was 45 volumes per cent. The plasma chlorides were 739 mg./100 cc. or 126 m Eq. The total proteins were 5.16 gm./100 cc. with an A/G ratio of 0.65. The icterus index was 21.0. A blood culture yielded Beta hemolytic streptococcus.

The patient was immediately given 5 per cent glucose in water intravenously to which 20,000 units of pencillin were added. The first day he was given 120,000 units of penicillin divided in equal doses given two hours apart. On the second day he received 200,000 units by continuous drip method. The patient was placed in an oxygen tent. There were rales in both lungs and an X-ray of the chest revealed mottling, thought to be multiple infarcts with possible abscess formation. The abdomen was "protuberant and doughy". The blood culture became negative and he was much more alert. On the next day the patient became worse; he had both peripheral and pulmonary edema, and was cyanotic. On the last day of life B. coli was cultured from the blood stream. The patient died on the 5th hospital day.

Autopsy. At autopsy, the principal findings were organizing acute pylephlebitis, multiple abscesses of the liver, diffuse acute periportal hepatitis, focal subacute myocarditis and bilateral bronchopneumonia. Localized acute fibrinopurulent peritonitis was present in the region of the stump of the appendix, and two fistulae communicated between the cecum and peritoneum. In addition, there was acute diffuse nephrosis. The postmortem blood culture yielded non-hemolytic B. coli.

COMMENT

Pylephlebitis is not a common disease but it is present in approximately 1 to 5 per cent of those dying from appendicitis[1] and in 0.1 to 0.4 per cent of all cases of appendicitis. Pylephlebitis is usually fatal but some cases are said to have recovered following both surgical and medical treatment.

Although other diseases may precede pylephlebitis, it probably most commonly complicates acute appendicitis. According to Crossland[2], it is more likely to follow appendicitis if the inflammation is marked. When pylephlebitis develops, an infected thrombus probably is always present in the appendical vein and extension to the portal vein and liver occurs in one of two ways; by direct extension or by embolism. At first the inflammation is limited to the intrahepatic veins, but gradually it spreads to the surrounding structures and in this way hepatic abscesses are formed. Blood cultures may become positive and pyemia may be a terminal manifestation.

The symptomatology of this condition is not uniform and the diagnosis unfortunately is frequently not made until late. According to Stewart-Wallace[3] the outstanding early symptom is a chill. Usually there is abdominal pain and tenderness, especially on the right side. The liver is often tender and may be enlarged. Hawkes[1] also believes that a chill is an important early symptom, and stresses the opinion that this chill may have been an early symptom in the disease prior to operation.

Treatment of these cases may be either surgical or medical. Formerly surgical operation was advised strongly and in appropriate cases was done prophylactically. Surgical treatment usually consists of ligation of the ileo-colic vein, although sometimes the superior mesenteric itself is ligated. Obviously, if emboli have already broken loose from the thrombus, ligation is of no value. Ottenberg and Berck[4] report two cases treated with sulfanilamide. In one of these the diagnosis was purely clinical; however, the patient had chills, abdominal pain, fever, liver tenderness and jaundice. The other patient was operated on and a biopsy revealed perivenous liver abscesses. Both of these patients recovered.

Because of the success in treating certain cases

*This is the nineteenth of a series of "Case Records Presenting Clinical Problems", selected by H. T. Karsner, M. D., from the Clinical Pathological Conferences of the Institute of Pathology, Western Reserve University and University Hospitals, Cleveland.

of septicemia and other severe infections with penicillin, it was used in this case. The patient showed initial improvement as evidenced by a slight drop in temperature and marked improvement of the patient's mental alertness. In addition, the blood culture became sterile. Nevertheless, the patient did not recover. Although the blood stream had been sterilized, it is likely that deep seated abscesses were present before treatment by penicillin was begun. It is at least possible and indeed probable that diffusable therapeutic agents do not penetrate into the depths of abscesses and do not affect the centrally situated bacteria. The same question arises in connection with all therapy by either biologic products, such as penicillin, or various chemo-therapeutic agents.

This case is not to be debited as a failure of penicillin treatment. Therapy was instituted too long after onset of the disease, when abscesses were already present and parenchymal degeneration had occurred. It is possible that early in the course of this form of disease, penicillin may be effective and should be used in this grave complication of appendicitis.

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Modern Concept of Tuberculosis

Although tuberculosis has afflicted mankind for centuries, even today many of its aspects lack clear definition. A view of this disease over the years reveals that it is rampant during periods of stress and strife, and quiescent in times of peace and prosperity. As a result of this second World War, the mortality rate of tuberculosis has greatly increased in many parts of the world. In Scotland, the death rate from the disease is 33 per cent higher than it was the year prior to hostilities, while in Hong Kong there were approximately 6,000 deaths in 1940 compared to 4,000 in 1939.

During the first World War the mortality rate in the United States rose 15 per cent. Today the downward trend has slowed up considerably, and a great increase is anticipated. The public is affected by the increased tension and the deprivations necessarily imposed during a war time regimen. Lowering of resistance through malnutrition, overexposure in bombproof shelters, rationing of food and clothing, and the acceleration of industry leading to mass migration to and from crowded quarters in industrial districts favor infection with and the spread of tubercle bacilli. At present, 1 per cent of selectees is rejected on account of tuberculosis at the induction centers, and an equal percentage is turned down for this reason by the local draft boards.

During the last few decades, there was an extraordinary reduction in the mortality caused by the disease, so much of one, in fact, that a great deal was said of the eradication rather than the control of tuberculosis. How much this reduction was influenced by antituberculosis programs, improved social and economic factors, and the wavelike movement of the epidemic cycle of the disease is difficult to estimate. Certainly, increased medical knowledge has had a leading role in this reduction. Today, tuberculosis is still the leading cause of death in the 15 to 45 year age group, but more deaths occur from the disease in persons between 60 and 70 years of age than in any other age group. At present, for each death 2 new cases are reported to health departments. It is estimated that there are at least 5 clinically active cases for each death. The disease flourishes where unfavorable socioeconomic conditions exist.—Arthur J. Logie, M.D., Miami, Fla.; Jour. Florida Med. Assn.; Vol. XXX, No. 9, March, 1944.

Macrocytic Anemia

The macrocytic anemia of cancer of the stomach can simulate that of Addisonian pernicious anemia quite accurately. In the presence of the least suspicion of cancer, the patient should at least have a gastric series of X-rays including fluoroscopy.

Macrocytic anemia may also occur with cirrhosis of the liver. Here the cell size is not markedly varied and liver disease is apparent. The anemia of myxoedema and, infrequently, diabetes, may cause diagnostic error. Leukemia with low white count may cause an anemia similar to the macrocytic type. The same may be said of idiopathic "aplastic anemia." In the former a bone marrow biopsy and a therapeutic test with liver extract may be helpful. In the chronic aplastic anemias there are no central nervous system signs and glossitis is uncommon.

The anemia of pellagra may resemble Addisonian pernicious anemia. Here there is vitamin B deficiency. In temperate and colder zones this deficiency is commonly associated with chronic alcoholism. The tongue becomes fiery red, sores develop in the corners of the mouth, the forearms and hands are the site of scaly eruptions, the mind becomes affected, and anemia develops. Since crude liver preparations contain some of the B complex it may help some but is not nearly so effective as large amounts of the vitamin itself.—Lloyd H. Berrie, M.D., Caribou, Maine; Jour. Maine Med. Assn., Vol. 35, No. 3, Mar., '44.

Pneumococcus Meningitis Treated With Penicillin: Report of Case

FRANK MEOLA, M.D.

Hospital No. 48031, an only child, aged 6, white, female, was admitted to the Medical Service of the Children's Hospital of Akron on November 24, 1943, with chief complaint of pains in the abdomen and head. On November 20, 1943, patient began with fever, vomiting and a sore spot in the abdomen. She gradually developed a headache, became irritable, and went into a semi-conscious state. No history of exposure. Developed no rash, no sore throat, or earache. Past history irrevelant other than she had had measles and smallpox.

PHYSICAL EXAMINATION

Physical examination showed a well developed and nourished child of 6, delirious and semi-comatose. Head, eyes, ears were negative. Neck showed marked rigidity and child bitterly resisted any motion of the head. The throat was markedly injected and red. Tonsils red and edematous. Chest was of normal configuration and expanded well. The lungs were clear to auscultation and percussion. The heart was not enlarged, regular, and showed no murmurs. The abdomen was moderately distended. No pain or tenderness to examination. Liver, spleen, and kidneys were not palpable. Reflexes showed hyperactive patellars and achilles. No clonus. Babinski was physiological. Pupils reacted to light and accommodation. Kernig's and Brudzinski's were positive. The temperature was 102.2F, pulse rate 142, respiratory rate 40.

CLINICAL COURSE

The child was put to bed and a spinal puncture done. The fluid was cloudy, under pressure. The cell count was 600 with 75 per cent polymorphonuclears and 25 per cent lymphocytes, one plus globulin. Gram stain smears showed Gram positive diplococci which on culture proved to be type 18 pneumococcus. The red blood count was 4,600,000, 12.5 grams hemoglobin, white blood count 19,500 with 20 per cent lymphocytes and 80 per cent polymorphonuclears. The urine was scanty, acid, specific gravity of 1.026, three plus albumin. Otherwise negative except for the presence of "sulfa" crystals which came from the drug started on admission. Cultures of spinal fluid remained positive to November 26, 1943. Thereafter it remained negative. The smear showed organisms by Gram stain until November 27, 1943, and none thereafter.

TREATMENT

Following admission the patient was placed on sulfadiazine and received on day of admission 3 grams of the sodium sulfadiazine intravenously and 2.5 grame of sulfadiazine by mouth part of which was vomited. The following day she received 2 grams of sodium sulfadiazine intravenously, 3.5 grams by mouth which was partly vomited. Fifty thousand units of type 18 anti-pneumococcus serum was given intravenously and 50,000 units intraspinally. The following day (November 26) she received 2 grams of sulfadiazine by mouth. Sulfadiazine blood level at this point was 16 milligrams. In spite of this treatment the child showed no clinical improvement, she remained very irritable even though the temperature dropped to 99.8 F, pulse rate 110, and respiratory rate 22. The spinal fluid on November 25 showed a count drop to 170 total cells with 95 per cent polymorphonuclears and 5 per cent lymphocytes. The globulin was increased. The smear still showed organisms but not in heavy numbers as on admission.

Due to the toxic appearance of the patient and the increased nuchal rigidity and delirium, the sulfadiazine was stopped and penicillin started at noon, November 26, 1943. The patient was given an initial intraspinal dose of 10,000 Oxford units. This was repeated every twelve hours. An initial intramuscular dose of 10,000 Oxford units was given and the dose repeated every three hours. This dosage and schedule was continued for three days, during which improvement was so marked that the dosage was dropped to 5,000 Oxford units intraspinally and intramuscularly on the same time schedule. Improvement was sufficient and the spinal fluid continued to show progressive clearing with negative culture and smear that penicillin was stopped on December 5, 1943. Total treatment with penicillin lasted nine consecutive days. Total quantity given was 620,000 Oxford units, 135,000 intraspinally and 485,000 Oxford units intramuscularly. The patient progressed uneventfully and further treatment was not found necessary.

The patient received a series of eight 100 cc. whole citrated blood transfusions for supportive

The Author

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Detail of Spinal Fluid Changes During Treatment

Date	Route	Amount	WBC	Globulin	Spinal Sugar	Blood Sugar	Smear	Culture
11-24-43	Spinal	10cc	600	1+	—	—	+	+
11-25-43	Spinal	10cc	170	2+	None	—	+	+
11-26-43	Spinal	10cc	4,850	3+	—	—	+	0
11-26-43	Spinal	10cc	11,000	2+	—	—	+	0
11-27-43	Spinal	10cc	5,250	4+	—	—	+	0
11-27-43	Spinal	4cc	7,200	3+	—	—	0	0
11-28-43	Spinal	3cc	2,258	—	—	—	0	0
11-28-43	Cisternal	15cc	1,120	3+	—	—	0	0
11-29-43	Cisternal	10cc	8,280	4+	—	—	0	0
11-29-43	Cisternal	10cc	1,600	2+	—	—	0	0
11-30-43	Cisternal	10cc	2,500	2+	—	—	0	0
11-30-43	Cisternal	10cc	731	2+	—	—	0	0
12-1-43	Cisternal	10cc	600	+	—	—	0	0
12-1-43	Cisternal	10cc	461	Trace	—	—	0	0
12-2-43	Cisternal	10cc	520	+	—	—	0	0
12-2-43	Spinal	4cc	1,640	+	—	—	0	0
12-2-43	Cisternal	10cc	245	2+	—	—	0	0
12-3-43	Cisternal	10cc	120	2+	—	—	0	0
12-3-43	Cisternal	13cc	130	—	—	—	0	0
12-4-43	Cisternal	10cc	160	+	—	—	0	0
12-4-43	Spinal	10cc	690	+	—	—	0	0
12-4-43	Spinal	10cc	510	Trace	50mg.	—	0	0
12-10-43	Spinal	10cc	330	Trace	50mg.	—	0	0
12-11-43	Cisternal	10cc	30	+	55mg.	110mg.	0	0
12-11-43	Spinal	10cc	283	+	50mg.	—	0	0
12-16-43	Cisternal	12cc	22	—	60mg.	70mg.	0	0
12-16-43	Spinal	6cc	10	—	—	—	0	0

treatment and anemia. During her hospital stay the red cell count ranged between 3,640,000 and 6,520,000. The white cell count ranged between 19,500 to 9,800. The differential ranged in lymphocytes between 12 per cent to 32 per cent; the polymorphonuclears between 88 per cent to 68 per cent. Under sulfadiazine the spinal showed an increasing cell count and globulin.

With penicillin the spinal fluid showed little change for a few days and then began to show a progressive clearing by reduction in total cell count, less globulin and increase in the spinal sugar. On admission the spinal fluid had no sugar whatever. At the end of the second day of penicillin treatment the spinal tap did not produce a free flow of fluid and little fluid was obtained. We felt a partial block was present and began to do cisternal punctures as well as give the drug by that route. The block never became complete and eventually cleared completely. The spinal fluid cleared slowly and some of this may be the effect of penicillin irritation. Following the start of penicillin, the temperature rose to 101 F, then to 103 F, from where it dropped progressively with a concomitant drop in the pulse rate and both came to normal on the seventeenth day after start of the drug to remain there for the balance of the hospital stay.

The patient's general condition gradually improved for the first three days and then more rapidly. The nuchal rigidity became less and negligible after the seventeenth day. The urine remained negative except for a few white cells on two occasions during the hospital period. There were no reactions other than a mild flush and headache at the time of injection of the drug into the spine or cistern. Patient was up in chair on sixteenth hospital day, in wheel chair on twenty-third hospital day, and went home thirty days after admission. The only complication was a mild pharyngitis with temperature elevation of 101 F on the twenty-first hospital day. This cleared promptly.

CONCLUSION

We feel that even though the spinal fluid showed early disappearance of the pneumococcus from smear and culture, the clinical picture of the patient was aggravated rather than improved. Although recovery with sulfadiazine might have been possible, it was not probable particularly since patient began to develop spinal block which cleared under penicillin treatment. In general, clinical improvement was rapid with penicillin. The period of treatment was short. The spinal fluid did not clear rapidly, probably a result of drug irritation.

Varicose Veins

Varicosities of the extremities are among the commonest disabilities encountered by the physician, and we may expect an increase in vascular disease due to our present demands upon those employed in war plants. Where the Trendelenburg test is positive, the method of choice for treating varicosities of the lower extremities is high ligation and injection.—Russell W. Lamb, M.D., Indianapolis; Jour. Ind. State Med. Assn.; Vol. 37, No. 1, January, 1944.

Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

There is now a strong tendency to "diagnose" tuberculosis by short-cut and sometimes slipshod methods. Recently, a few physicians were asked how they would proceed to find all of the tuberculosis among the population of an entire industry or country. One stated that increased red cell sedimentation rate would ferret out all cases. Another would discover them by finding acid-fast bacilli in their sputa. Still another would employ only X-ray film inspection of their chest. Other similar methods were offered. Each physician presented an important phase of an examination, but not one of them was adequate. To achieve a satisfactory diagnosis each one of this group of physicians would have to examine a given individual in his own way, then pool his findings with those of his colleagues—a wasteful and illogical procedure.

IS BACILLI PRESENT?

There can be no tuberculosis in the absence of tubercle bacilli; therefore, the first phase of an examination is to determine whether bacilli are present. This can be done by the tuberculin test, which is accurate and specific except in the first few weeks after infection occurs, and in acutely ill and terminal cases. Other failures are usually due to the use of impotent tuberculin or to improper administration. Under proper conditions, then, a non-reactor to tuberculin can be told that he does not have living tubercle bacilli in his body. On the other hand, a reactor has at least primary lesions which contain living tubercle bacilli. Exceptionally, and only when all bacilli die, allergy persists for a time, then wanes and disappears. Inasmuch as primary tuberculosis is a prerequisite for the clinical forms, it is of extreme importance to know whether it is present. The tuberculin test provides this information with uncanny accuracy. With the exceptions mentioned, it is with great rarity that the person with clinical tuberculosis fails to react to tuberculin.

X-RAY OF CHEST

The next phase of the examination consists of inspecting the chests of all adult reactors with the X-ray. On the ordinary film 25 per cent of the lung parenchyma is obstructed from view by shadows of such parts as the heart and diaphragm. Films fail to reveal evidence of primary tuberculosis in 70 to 80 per cent of the persons in whom it actually is present. So, too, may lesions of the reinfection type, because of their size and consistency, escape detection. It is a common experience to view a film which appears clear, yet one of the same chest a few months later reveals evidence of disease. Therefore, adult tuberculin reactors whose lungs appear normal should have films at least annually.

After tuberculosis lesions of the reinfection type attained macroscopic (gross) proportions, X-ray inspection is by far our best method of detecting their locations when they are in that part of the lung which is visualized; indeed, they cast shadows on an average of two or three years before they cause significant symptoms. However, final diagnosis should never be made from X-ray shadows, since those cast by tuberculosis lesions may be indistinguishable from those of numerous other pulmonary diseases, such as sarcoidosis, silicosis, malignancy, fungus infections, abscess, and pneumonia. When a lesion is found, its etiology can usually be determined by other methods.

LAUDABLE, BUT NOT ENOUGH

The present, widely used procedure which begins with X-ray inspection of the chests of large groups of adults is laudable, provided it does not end there. All concerned must be informed that (1) X-ray inspection is done with the unaided eyes and reveals nothing but macroscopic (gross) lesions; (2) one-fourth of the lung parenchyma is obstructed from view by shadows of other parts; and (3) final diagnosis cannot be made with accuracy from X-ray shadows. Thus, the tuberculin test screens out those persons who have living tubercle bacilli in their bodies, and from them the X-ray screens out those who have gross lesions which may be tuberculous. Neither nor both procedures constitute an adequate examination.

To determine whether a demonstrable lesion is tuberculous one must seek tubercle bacilli in material obtained from it. Among individuals with extensive tuberculous lesions these are usually promptly recovered from the sputum. When bacilli are not found in more than one of several specimens, or if no sputum is present, gastric lavage may reveal their presence. Visualizing acid-fast organisms by the aid of the microscope may not be sufficient because of laboratory errors and also because nonpathogenic, acid-fast bacilli are sometimes found in the sputum and gastric contents; therefore, their pathogenicity should be determined by culture on artificial medium or by animal inoculation. In the event tubercle bacilli or other pathogenic organisms are not recovered, one should observe frequently new X-ray films to determine whether abnormal shadows persist or any significant changes occur

in or around them. However, among persons beyond thirty-five years one should avoid delay, as the lesion may be malignant. In such case the bronchoscopist should be consulted, as he may promptly reveal the etiology.

PATIENT MUST BE INTERVIEWED

There is no more deplorable practice than to have tuberculin tests administered and X-ray films prepared, after which the physician makes diagnoses without seeing the subject and completing the examination. The individual should always be interviewed by the physician. While most persons have no symptoms for an average of two to three years after the disease can be located and practically none of those with primary tuberculosis give histories of significant illness, the tuberculin reactors whose chest films are entirely clear may relate symptoms caused by extra-thoracic tuberculosis. Indeed, they may be developing acute conditions, such as meningitis or miliary disease, or chronic lesions in such parts as the kidneys, pelvic organs, and bones and joints.

Following the interview, even though no significant evidence is obtained, the remainder of the traditional physical examination should be made, since significant pulmonary signs may be elicited from lesions located near the periphery or in parts of the lungs not visualized by X-ray; moreover, lesions may be found during the scrutiny of extra-thoracic regions.

To summarize: Tuberculosis begins when the first tubercle bacilli enter the human body and are focalized in microscopic lesions. At this stage the disease may lie dormant or may even disappear. Again, it may undergo exacerbations and remissions resulting in every form of clinical tuberculosis to which the human body is heir. The physician can now diagnose tuberculosis within a few weeks after the first invasion of tubercle bacilli, and he can detect most of the subsequent lesions with considerable promptness. Either to diagnose tuberculosis when it does not exist or to fail to find it when it is present, is inexcusable. Nearly all errors in diagnosis are due to short-cut or slip-shod methods and may be avoided by employing every phase of a complete examination. —Tuberculin Test, X-ray and Other Diagnostic Aids, J. A. Myers, M.D., Journal-Lancet, April, 1944.

Cancer of the large bowel is somewhat commoner in males than in females in the ratio of 1.4 to 1, and it is a disease of later life. Eighty per cent of patients at the state cancer hospital are from 41 to 70 years of age with an average age of 58.5 years.—Everett D. Sugarbaker, M.D., Columbia, Mo.; Jour. Mo. State Med. Assn., Vol. 41, No. 3, March, 1944.

Refractory Bacteria in House Dust

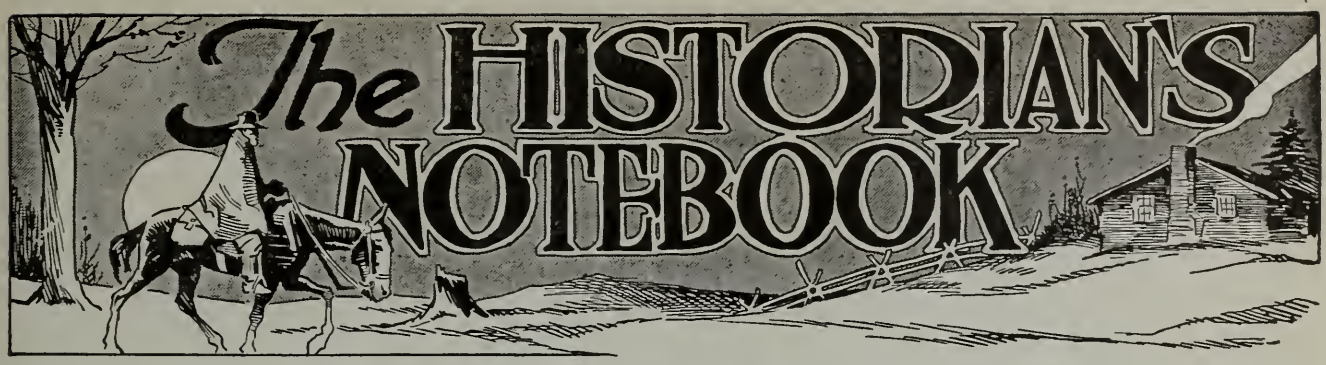
About forty other germicidal mists were subsequently tested against nebulized bacterial cultures by Twort and his co-workers of the Portslade Laboratories, Sussex, England. The British investigators developed a mathematical theory of nebular disinfection based on the probability of collision between mist droplets and air-borne bacteria. From this theory it was logically deducted that balsams and other substances of low vapor pressure would be the antiseptic aerosols of greatest clinical efficiency.

Since then propylene glycol and triethylene glycol have been chosen by most American investigators as the aerosols of greatest promise. These two are nontoxic, odorless, tasteless, nonirritating to the respiratory mucosa and of high antiseptic titer, one gram of propylene glycol vapor in 2 to 4 million cubic centimeters of air, producing immediate and complete sterilization of air into which pneumococci, streptococci, staphylococci, H. influenzae or influenza virus have been sprayed. Complete sterilization requires a longer period of time with lesser concentrations. Pronounced bactericidal effects are noted with concentrations as low as one gram in 50 million cubic centimeters of contaminated air.

Contrary to the earlier contact theory, Robertson and his colleagues found that fully vaporized propylene glycol is most efficient. They also demonstrated an increased efficiency of propylene glycol vapor at lower temperatures. At 60 degrees Fahrenheit it is twice as effective as at 95 degrees Fahrenheit, with an intermediary efficiency at 75 degrees Fahrenheit. Marked differences in bactericidal action were also noted with different degrees at atmospheric humidity.

The demonstrated effect of altered humidity led to a study of the relative susceptibility of moist, partially desiccated and fully desiccated bacteria. Their most striking observation was their demonstration that propylene glycol vapor is without bactericidal effect on the fully desiccated bacteria of ordinary room dust. This suggests a hitherto unsuspected refractory phase for environmental bacteria or as they believe, a certain type of union between dust and bacteria that will protect the microörganisms against the action of bactericidal vapors. This may conceivably be due to the formation of a repellent surface film on dust bacteria.

This finding is of major clinical interest, since "In order to effect sterilization of ordinary room air it is clearly necessary to acquire much more information concerning the physical state of micro-organisms associated with dust, and to develop means of effective dust control."—W. H. Manwaring, M.D., Stanford Univ., Calif.; Calif. and Western Med., Vol. 60, No. 2, Feb., 1944.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

The History of Human Dissection

LINDEN F. EDWARDS, Ph.D.

THE history of science portrays not only the development of science per se but it also throws light upon intellectual and social history in general. This truism is especially evident when the history of human dissection is traced in a chronological manner. Analysis of the status of human dissection in any given period reveals rather faithfully the social and intellectual conditions of that period because of the interrelation of the methodology and the nature of the subjects employed. In short the history of human dissection is a story of the conflict between a deep-rooted human tendency to protect the dead and the scientific spirit which demands human subjects for dissection. This paper is an attempt to outline that story for the benefit of the present generation of medical students who, as Corner ('30) aptly expresses it, put their hands to a task which other men dread, and join the company of those who have laid aside the deepest fears and prejudices of mankind, to seek in the dead bodies of their fellows some increase of knowledge wherewith to fight the ignorance and disease that laid them low.

The Author

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FIRST RECORDS

The beginnings of human dissection, like the advent of anatomical observation and knowledge, are veiled in obscurity due to the lack of authentic records. Although we date the birth of Anatomy as a scientific discipline, like so many other branches of science, back to Grecian civilization, it is common knowledge that the Greeks were preceded by Oriental civilizations, e.g., the Egyptians, Babylonians and Hindus, from whom they derived a certain heritage.

From the scanty evidence at our disposal we can only infer that these Oriental peoples possessed some body of anatomical knowledge. The principal and most authentic sources of our knowledge of Egyptian anatomy are the medical papyri, some of which date back to 1500 B.C. These not only describe certain surgical procedures demanding considerable anatomical knowledge but they also give accounts of the structure of the human body however bizarre they may be. Antedating these medical documents are certain hieroglyphics dating as far back as 4500 B.C. which are said to represent the heart, trachea and lungs and the female reproductive tract. Moreover, certain of their works of art, such as amulets and engravings on vases and the walls of tombs, suggest that they had some access to human anatomical sources. It is well known that Egyptians practiced the art of embalming. The claim has been made, however, that in spite of this established fact there is little likelihood that they carried on human dissection or that the practice of embalming could have resulted in their acquisition of much anatomical knowledge, since the Egyptians held as odious anyone who did violence to the human body. In fact we know from their description of the ceremony of embalming that the "parachiete" or cutter who made the initial abdominal incision for the removal of the viscera was of the lowest caste and was held in great aversion even to the extent of being pursued by the angry spectators and pelted with stones.

In the absence of sufficient evidence to the

Read at the meeting of Phi Delta Epsilon, honorary premedical fraternity, Ohio State University, Oct. 23, 1943

contrary and in view of the fact, as historians emphasize, that the universal oriental attitude toward the human body was that the corpse was abhorred, shunned and considered unclean, it does not seem likely that the orientals practiced human dissection.

THE CHINESE

Even though the ancient Chinese civilization did not likely influence Grecian civilization, it is of interest to point out here that human dissection was practiced by the Chinese as early as 2500 B.C. as evidenced by the oldest Chinese medical classic, the Nei Ching or Canon of Medicine, which contains the statement "the human body may be dissected and observations made as to the size of the organs, the capacity of the blood and the amount of pneuma". The weights and measurements of the various organs are then enumerated.

In regard to the status of human dissection during the "glory of the Greeks! who first didst chase the mind's dread darkness with celestial day" (Lucretius) it is an open question whether or not their superstitious respect for the dead or their stringent laws regarding immediate burial prevented dissection of the human body. Included among the various works of the Hippocratic Collection composed between 500 and 300 B.C. appear the earliest complete anatomical treatises on record, some of which tend to show that if the writer had not practiced human dissection he was at least familiar with some form of post-mortem examination.

It is generally conceded that even Aristotle (384-322 B.C.), who is accredited variously as the founder of Natural History, the Father of Comparative Anatomy and the great codifier of ancient science, never dissected the human body. As evidence for this it is pointed out that his famous work "The History of Animals", which describes the organs of lower animals and compares them with man, contains so many inaccuracies in human anatomy as to render impossible the idea that he ever could have practiced human dissection. The name of Aristotle is, however, linked with an important chain of events in the history of human dissection. His influence over his famous pupil, Alexander the Great, resulted in the latter's encouragement of the biological sciences in all the countries he conquered an encouragement which was eventually climaxed in the founding of the great Library and Museum of Alexandria, Egypt. After the fall of Alexander's empire, the center of learning moved across the Mediterranean to Alexandria, where anatomy first became recognized as a distinct science and where for the first time in recorded history human dissection was openly permitted by the reigning king, Ptolemy Soter I, one of Alexander's former generals to whom Egypt was bequeathed. History tells us that the first anatomists to have been granted this rare privilege were two members of the medical faculty, namely Herophilus and Erasistratus (300 B.C.), the achievements of whom inaugurated what is referred to as the "Alexandrian period" (300 B.C.-200 A.D.) of Anatomy. The names of these two pioneers in human dissection were linked with a scandalous accusation by writers as late as 400 A.D. who accused them of having practiced vivisection of condemned criminals by royal permission. Critics have long occupied themselves in answering this charge, proof of which is doubtful. It is quite probable that these charges originated in the popular imagination which has always been more or less prejudiced against dissection of the human body.

PTOLEMAIC DYNASTY

With the final extinction of the Ptolemaic dynasty by the death of Cleopatra (30 B.C.) and with the absorption of Egypt into the Roman Empire anatomical study at Alexandria began to wane. Although it remained for many years the chief center of anatomical teaching and attracted many students from all parts of the known world, human dissection had ceased by the middle of the second century A.D. Its practice was not revived anywhere till the rise of mediaeval universities during the 13th century.

During these thousand years of darkness anatomy fell prey to monastic medicine, when the Christian Church, through her monasteries closed down medical schools and prohibited human dissection under pain of excommunication. Throughout this period the Christians perfected a way of thinking, now termed Scholasticism, which is characterized by deep respect for authorative statements. Of the many students who came to Alexandria to receive training in Anatomy was Claudius Galen (130-200 A.D.), the last of the great line of Greek physicians and philosophers, and whose writings were destined to control man's knowledge of his structural self for 1300 years. This amazing fact becomes all the more impressive when it is realized that his descriptions of human structure were compiled without benefit of dissection of the human body. Authorities cite as evidence for this that human dissection had ceased at Alexandria at the time of Galen's attendance there and that his works describe for the human body structures peculiar only to lower forms, such as the ape and ox. The explanation offered for the survival of his works throughout the Dark Ages is that his philosophical ideas were in agreement with the theological attitude of the Church along with the lack of independent observation and investigation.

THE SALERNO SCHOOL

The earliest medical school to be founded in Europe was at Salerno, Italy, a name now fa-

miliar to every American, since everyone is aware of the establishment there of a bridge-head by the gallantry and blood-shed of the American Fifth Army. Although a medical school was established there as early as the year 900 and it remained for many years the medical center of all Europe there was, however, no practical anatomical instruction, since the atmosphere was scholastic and the texts used were Arabic translations of Galen's works. Revival of the practice of human dissection occurred rather at Bologna in northern Italy where, it is claimed, was founded the first institution in existence to which the term university can be rightly attached. It appears first in history as a Law School, although, an organized Medical Faculty existed there as early as 1156. Since the Medical Faculty was under the jurisdiction of the Law Faculty, it seems probable that opening of the human body at that university began as public or semipublic post-mortems for the purpose of gathering legal evidence. The earliest records of these public dissections place the date at about 1300. As time went on these post-mortem examinations, always under the watchful eye of a monk and jurist, passed into anatomical study, which, however, did no more than to verify Galenic anatomy. In case discrepancies were observed between Galen's descriptions and the actual structure of the organs exposed they simply passed it off by arguing that the structure of the human body had changed since the time of Galen.

To Mondino de Luzzi or Mundinus (1270-1326), a professor of medicine at Bologna, belongs the credit for restoring the practice of human dissection into the study of medicine. He is the first teacher known to have taught anatomy from the human cadaver and even the exact date is known when the practice was resumed. The body was that of an executed criminal, which was dissected January, 1315, in public. In 1316 Mondino published his "Anathomia" which was in reality a manual of dissection combined with an explanatory text. Although it was full of Galenical errors it remained a standard textbook on anatomy for 200 years. Physicians and anatomists everywhere should pay homage to Mondino, not simply because he is with justice called the "Restorer of Anatomy" but because of the courage he displayed when he risked not only the deep seated prejudice of the people, with their superstitious respect for the dead, but also the opposition, authority and direct hand of the Church, which opposed human dissection because it believed it to be a desecration of the human body. It should also be emphasized that Pope Boniface VIII had issued in 1300 a famous papal bull excommunicating anyone who dared to cut up a human body. This was commonly believed to include dissection for anatomical study, although recent investigation tends to show that the papal bull was issued in an attempt to stop the practice among the Crusaders of cutting up the bodies of distinguished persons who died in the Holy Land and of boiling the bones in order to better transport them to Europe.

MONDINO

From the time of Mondino throughout the 14th and 15th centuries the practice of human dissection in public slowly gained recognition in the universities. The authorities at first closed their eyes to the practice and took no action in the matter until at last feeling became so strong in the medical centers that the desired official sanction was obtained to dissect publicly two bodies a year in each center of medical instruction. It is interesting to note that the first ecclesiastical authority to give official sanction to the practice was Sixtus IV (Pope 1471-1484) who himself had been a student at Bologna and Padua.

Another fact concerning Mondino that should be emphasized is that he dissected in person, for which reason he is deserving of more credit and esteem than his successors until Vesalius. As human dissection became officially recognized and included in the medical curriculum the occasions evolved into elaborate affairs attended by oftentimes hundreds of spectators and conducted with much ceremony. The professor in charge, quite unlike Mondino, occupied in truth a chair which was an elevated structure provided with steps and a reading desk much like a pulpit. From his high position he read a standard text, either Galen's or Mondino's, while an ostensor pointed out the lines of incision and a menial demonstrator, commonly a barber-surgeon, performed the actual dissection. In spite of the facilities offered the medical schools for obtaining human anatomical material and with the limitations imposed by the formalities of public dissections anatomy made little progress during the next two hundred years.

In the meantime Europe experienced an intellectual awakening, now referred to as the "Renaissance", which was due in great measure to the invention of printing, about the year 1450 by Johann Gutenberg of Mainz, Germany, and to the introduction of wood engravings, as a result of which books were cheapened and culture was spread broadcast. Thus began a revolution in education, to which the term "Humanism" is applied, characterized by a spirit of individualism and of the arousal of curiosity in matters hitherto neglected. Human life and this world came to be viewed as things good in themselves and not merely as a means of preparation for the world to come, as was emphasized during the Middle Ages. A new and exaggerated interest was taken in the classical authors and under the

impulse of the new love for learning the libraries of the monasteries of Europe were ransacked and many lost classics were recovered. The recovery of ancient classics had its effect on the study of Medicine, notably Anatomy. By the 16th century all the medical classics that we now possess, including the anatomical works associated with the names of Hippocrates, Aristotle and Galen had been recovered and translated into Latin versions. As a result of these translations there entered Anatomy a large number of Latin terms still in use. The immediate reaction of anatomists to the recovery and translations of the Greek scientific texts was marked by a keener appreciation of Galen's writings, so that for the time being anatomy was served not so much by the scalpel as by scholastic traditionalism.

THE FIRST TEXTBOOK

One of the first changes to be noted in Anatomy was the publication in 1521 of a book entitled "Commentary on the authorized textbook of Mondino" by Berengario da Carpi (1470-1530), Professor of Surgery at Bologna. This book is of great interest in that, in the first place it was the first textbook of anatomy to contain illustrations of the subject matter described; in the second place both Galen and Mondino are subjected for the first time to independent critical examination and in the third place it described for the first time the vermiform process, the arytenoid cartilages, the thymus and the larger proportional size of the male chest and of the female pelvis. Berengario is thus credited as the first independent anatomical investigator of modern times. He is said to have performed many dissections and at first received great honour. However, the old ghost of popular prejudice soon raised its ugly head and he was accused of having dissected some living Spaniards in order to observe the movements of the intestines, thus illustrating the moribund state of anatomy during this period.

Although the great artists of the Renaissance period, notably Michelangelo, Raphael and Leonardo da Vinci, had only a limited influence on the progress of anatomy it is of interest here to emphasize that they all used the scalpel to improve their art and most of them left drawings of their dissections. The anatomy notebooks of Leonardo are of especial interest in that they contain over 750 red-chalk drawings of his own dissections which are marvels of observation and insight. Unfortunately mis manuscripts remained hidden until recent years otherwise they might have advanced the progress of Anatomy by centuries.

VESALIUS

During the middle of the 16th century destiny sent a man who by his own efforts revolutionized the practice of dissection. That man was Andreas Vesalius (1514-1564), who is credited as the originator or "father of modern anatomy". While a medical student at the University of Paris he resolved to exert all his powers and means to the revival of anatomy and to raising the standards of dissection. His zeal for dissection was manifested when at the third dissection he attended he took the scalpel and, shoving aside the barber-surgeons, served as demonstrator. At Padua where he obtained his degree in medicine he was appointed Professor of Surgery and conducted regular public dissections in the anatomical amphitheatre, continuing the practice of dissecting with his own hands and using his students as assistants rather than the clumsy barber-surgeons. He also betook himself into the sanctum of his own laboratory, away from public gaze, and there dissected many bodies, many of which are said to have been obtained in an illicit manner. He devised his own instruments and most important of all he cast aside Galenical traditions and substituted his own original observations compiling notes and making sketches. These he published in 1543 under the title of "Da Fabrica humani corporis" which contained 663 pages illustrated with many woodcuts. Following the publication of this book he became the target of criticism by his fellow anatomists who refused to accept his findings because they were contrary to Galen. He could not endure this bigoted opposition so, giving up anatomical studies, he accepted the post of court physician. Like his predecessors who had pioneered in dissection he was accused of human vivisection. Eventually, however, his influence on anatomical methods was felt and served to stimulate intensive investigation in the subsequent years.

The 17th century is characterized as an age of great advance in human anatomy, particularly in the discoveries and descriptions of internal organs, many of the popular names of which survive to this day as memorials to their discoverers. Many technical procedures of anatomical study were invented and improvements made in methods of illustrating details of dissections, such as copperplate engravings.

By the 18th century most of the gross features of the human body had been worked out and anatomical dissection had been well established all over Europe, the supply of cadavers being ample for frequent demonstrations. During this century the approach to human anatomy underwent a change, from that of descriptive to that of operative or surgical anatomy. Up to this time human anatomy had been taught by demonstrations on the cadaver by the professor or a prosecutor. But now operative surgery was undergoing rapid development and was passing out of the hands of barbers into those of skilled and educated surgeons. In order to acquire surgical

skill it was necessary for the student to have, along with technical precision, perfect memorization of the body parts. This need led to the regional and topographical approach which now characterizes the method of dissection. This need of practice in dissection resulted not only in the reorganization of anatomy courses in the medical schools but brought about extramural anatomical schools, such as that of William and John Hunter in London, where the students did their own dissecting.

DISSECTION IN ENGLAND

In England as early as the 16th century the need for dissection material led to the passage of a law by Henry VIII authorizing the barber-surgeons the use of four bodies of executed criminals each year. The great increase in the number of students attending the medical and anatomical schools toward the end of the 18th century in England, Ireland and Scotland resulted in a severe shortage of cadavers. As there was no public regulations to supply the demand, until the passage of the Warburton Anatomy Act in 1832, the practice of body-snatching and grave robbing was resorted to.

It is not the intention of the writer to indict or justify the anatomists of this period for their methods of obtaining dissection materal. However, it should be pointed out, for the sake of record, that as a result of the urgent necessity for bodies to supply the ever increasing demand of the rapidly expanding medical and anatomical schools, and of the long delay of indifferent governments in legalizing the use of unclaimed dead for dissecting purposes, in spite of the appeals of the medical profession, the anatomy professors were forced to obtain subjects for dissection by other than legal means. Under such circumstances there came into being professional "resurrectionists" who engaged in the repulsive and nefarious business of providing the schools with cadavers by the systematic robbing of graves. This resurrectionary period, characteristic of the 18th and 19th centuries, presents a gruesome page in the history of human dissection, a page besmeared with the deeds of men marked by greed, avarice and crime including even murder. Much has been written concerning the escapades, exploits, trickery and ingenuity of these "body-snatchers" and space will permit only a brief account here of some of the "tricks of the trade". Bodies were sometimes stolen before burial. One ingenious trick was that a man would steal a dead body, which lay awaiting an inquest, and sell it to an anatomist. Whereupon the man would give information to the police where to find it. The body would be restored to the coroner, who, after the inquest, turned it over to "relatives". The latter generally turned out to be confederates of the man who had stolen it and the corpse would be resold to the anatomist. Women were often confederates, posing as a "sorrowing mother" or a "bereaved widow". Under such guise they would go to an anatomical school and there with much grief claim the body of child or husband which they would remove and take to the next anatomical school to be resold. Or if a pauper lay dying in the workhouse, a hospital or lodging house they would claim the body as a relative, or, simulating philanthropy and pity would offer to pay for his humble grave. Another use which women often served was to go to a newly made grave to mourn as a "disconsolate relative" and incidentally to cut the wires leading to a spring gun, which had been planted to protect the grave.

GRAVE PROTECTION

Numerous methods were employed to protect graves such as watch towers, iron coffins and "mort safes" or strong iron grating. The latter device proved of no avail because the resurrectionists simply dug a sloping tunnel and drew up the coffin by means of iron hooks. The tunnel was then refilled and the unsuspecting relatives who came to weep over the apparently untouched and well protected grave mistook the recently disturbed turf nearby as a newly-made grave.

The grave diggers themselves oftentimes sold bodies and they could usually be bribed or made intoxicated. It became the custom to employ a private watch over a new-made grave, and the watch was often in league with the grave-robbers. Violent fights between the watchers and the gang of thieves sometimes took place, but the fights were usually between rival gangs, rivalry between them being very intense.

Failing to obtain dead bodies, some of the more reckless and avaricious body-stealers resorted to murder, the most famous case being that of Burke and Hare, who in 1827-28, committed sixteen murders and disposed of the bodies of their victims to Edinburgh anatomists. Their victims were made drunkenly unconscious, during which condition they were suffocated, or "burked", to use an expression coined at that time, in order that no marks of violence appear on them. When these crimes came to light the fury ran so high against the anatomists, who were looked upon by the public as a party to the crimes, that their lives were endangered. Hare turned state's evidence and Burke having been found guilty was hanged and befittingly his body was dissected. His skeleton now adorns the Anatomical Museum of Edinburgh University as mute evidence of the results of legal obstruction to and popular prejudice against human dissection during the "resurrectionary period" of anatomy. This state of affairs in Great Britain eventually culminated in the passing of an Anatomy Act (1832) legal-

izing dissection of all unclaimed bodies by the medical and anatomical schools.

The history of human dissection in the United States during the 18th and 19th centuries closely parallels that in Europe for the same period. Prior to the establishment of medical schools private courses in anatomy, including demonstrations, were offered by practitioners who had acquired their medical and anatomical training abroad. During this period the young aspirants to medicine who could not afford to study abroad received their training in medical practice through the apprentice or preceptor system which furnished no opportunity for practical dissection of the human subject. The private anatomy courses at first and short medical courses later provided the apprentices this much needed opportunity.

THE FIRST AMERICAN LECTURES

The first recorded private lectures and demonstration in Anatomy held in this country were by Thomas Cadwalader in Philadelphia (1730). The next recorded instance was in 1762 when William Shippen, Jr., who had studied under John Hunter of London and obtained a medical degree at Edinburgh, returned to Philadelphia, his native city, to practice and inaugurate a course of anatomical lectures and demonstrations, using the body of a negro who had committed suicide. Dr. Shippen subsequently became the first professor of Anatomy and Surgery (1765) in the first Medical School in the United States, namely the Medical Department of the University of Pennsylvania.

Organized anatomical instruction elsewhere during the 18th century followed close on the heels of Pennsylvania. Next at King's College (now Columbia University) then at the University of Maryland and then at the College of William and Mary. Eventually medical schools were established throughout the country. Unfortunately, however, the various states, which chartered or otherwise recognized the medical colleges, at first made no legal provisions by which the colleges could secure indispensable human material for dissection, as a result of which "body snatching" and "grave robbing", as in Europe, was resorted to.

The United States was not without a "burking" case for in 1886 three negroes were accused of murdering an old white woman. They sold her body to the University of Maryland Medical School and were sentenced to be hanged. Here, as in Europe, popular prejudice and the horror of human dissection often incited mob violence. For instance, the building in which Dr. Shippen held his anatomical demonstrations was attacked several times and the Doctor was often forced to flee under a shower of missiles. In 1788 popular prejudice against dissection in New York City culminated in the celebrated Doctor's Mob when several rioters were killed. During the same year a mob invaded a private anatomical school in Baltimore and stole away the body which was being dissected.

Doubtless few medical students of the present generation are aware that a medical college existed at Worthington, Ohio, at one time. It was called The Worthington Reformed Medical College and in the autumn of 1830 was the scene of a riot brought on by the disappearance of bodies from the Potter's field. Suspicion pointed to this College and when an infuriated mob arrived to search for the bodies President Morrow, seeing that resistance was useless, surrendered and agreed to close the college.

THE HARRISON CASE

An incident of great interest was the Harrison case, which occurred on May 30, 1878, at the Medical College of Ohio in Cincinnati. On that date John Harrison, brother of Benjamin Harrison who was subsequently President of the United States, visited the medical school, armed with a search-warrant, in search of the body of William B. Devin, a young friend of the Harrison family, who had died a few days previously and whose body had been stolen. He failed to find any trace of the body. However, to his great horror he found the body of his own father, John Scott Harrison, who was a son of William Henry Harrison, ninth President of the United States. Needless to say the fact that this man was the son of an ex-president caused the newspapers of the country to be full of the account and aroused public sentiment against the faculty of the medical school.

Although the practice of grave robbing brought medical schools and their faculties into disrepute with the public whom they served, the aroused public sentiment eventually resulted in most states in their enactment of laws which provided adequate supplies of dissection material from unclaimed pauper dead. The first state to enact such a law was Massachusetts (1831) followed soon after by New York.

In the Journal of the Proceedings of Convention of Physicians of Ohio held in Columbus January 5, 1835, appears the following resolution: "Resolved, That a committee of three members be appointed to report upon the expediency of memorializing the Legislature on the subject of legalizing the study of Anatomy. Drs. Kreider, Mitchell and Cooper were appointed said committee." That the efforts of this committee were of little avail is evidenced by the fact that it was not until March 25, 1870, that a bill to encourage the study of Anatomy was introduced into the Ohio Legislature. This bill was enacted by the fifty-ninth General Assembly into Ohio Law,

67-25. It stipulated that it shall be lawful to deliver to the professors of medical colleges and to members of county medical societies, that are auxiliary to a state medical society, the remains of any deceased person for the purpose of medical and surgical study provided that (1) said remains shall not have been interred, (2) if remains not desired for interment by any relative or friend or county or township officer within twenty-four hours after death, (3) if remains may be known to have relatives or friends they must have consented, (4) if remains are not detained for debt, or as a witness, or on suspicion of crime, or are not of any traveler or stranger, or have expressed a desire that their body be interred, (5) if remains be subsequently claimed by relative or friend they shall be given up to said persons for internment, (6) if remains be decently interred in some public cemetery after they have answered the purpose of study, and (7) if remains be used in this state only. The penalty for violation of the provisions of this law was a fine not to exceed one thousand dollars and imprisonment for a term not exceeding one year in a county jail.

THE AMENDED LAW

On February 19, 1881, this law was amended and codified as R. S. section 3763, which provided that the superintendents or directors of all public institutions supported by public expense in possession of bodies not claimed or identified and which must be buried at the expense of the public shall on the written application of professors of anatomy in any medical college or the president of any county medical society deliver to such professor or president for the purpose of medical or surgical study or dissection such bodies, after 24 hours from death. The present law, section 9984 G. C. O. was passed April 5, 1898, the general provisions of which are essentially similar to those in amended section 3763.

Thus, finally, as a result of legislative action and of a gradual enlightenment of public opinion the "barred road to anatomy" has been given a wide clearance for the medical student of the twentieth century to wend his weary way.

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Neuroses

In wars of the past little has been said or written concerning the hardships and vicissitudes met and endured by the civilian population. These things were taken for granted. It was understood that those in the home country must sacrifice for men in the fighting forces. Little has been said or written as to effect of war on the mental health of those in civil life.

The psychological reactions of the present conflict on the civilian population is entirely different from any war in the past; present-day methods of communication, visualization and transportation bring the terrible actualities of this war acutely to our senses even though it is being fought thousands of miles away. There was never a war in which the man at home was so thoroughly aware that his efforts were necessary for the successful termination of a world-wide strife. A war of such magnitude is reflected in business, finances, industry, and in fact in every vocation and profession, great or small. There is hardly a man or woman who is not in some way emotionally or physically disturbed in these turbulent days of global warfare. It seems reasonable to suppose that under the stress and strain, anxiety and hardship of this war there would be a marked increase of psychiatric ailments affecting those in civil life; and also under the circumstances of the present war, a higher percentage of the civilian population will be directly or indirectly psychiatrically disturbed than in any other war of the past.

The psychiatric reactions of an individual are ordinarily based on his fundamental make-up. It is generally understood that the individual who succumbs to a psychotic or neuropsychotic disturbance is one of a low emotional or imaginative threshold. At the same time, no one has ever defined the normal threshold level of the emotions or imaginations. No one has ever been able to show that this threshold is ever so high that it can not be surmounted by the proper stimulus. In other words, any individual, no matter of what intellectual attainment or apparent emotional poise, may be mentally submerged by an overwhelming psychic conflict. Again certain factors, physical or physiological, may so lower the threshold of emotionalism and imagination that the individual responds adversely to comparatively mild stimuli.—Larue D. Carter, M.D., Indianapolis; Jour. Ind. State Med. Assn.; Vol. 37, No. 2, Feb. 1944.

Proposals for Federal Management and Regimentation In Field of Public Health Assailed by Governor Bricker

GOVERNMENTAL management and regimentation which would become necessary under a program such as the one proposed in the Wagner-Murray-Dingell Bill would "inevitably lead to national chaos and disorder" and be "a distinct threat to the future health of our people", Governor John W. Bricker of Ohio warned in an address before the Creve Coeur Club of Peoria, Illinois, at that organization's annual Washington's Banquet on February 22.

Although Governor Bricker, who is a candidate for the Republican nomination for president, did not refer directly to the Wagner Bill, he left little room for doubt that he had that proposal in mind when he lashed at current movements to give the Federal Government complete domination over the field of public health.

SAYS FREE GOVERNMENT THREATENED

Charging the Federal Government with "extreme busybodying and meddlesomeness in many affairs that ought to be left to the people themselves" Governor Bricker stated that in his opinion "our institutions of free government are threatened as never before" because of existing bureaucratic, paternalistic and dictatorial policies and trends.

"It should be the function of government to serve the people, to help them help themselves", he said. "It is not the function of government to direct every act of the citizen in his daily life. To make matters worse, this administration has not gone as far as it wishes to go in the regimentation of our daily lives.

"Consider for example, the field of public health. Whatever governmental attention is proper or desirable in this field can be given much better by the states themselves or by private agencies who are closer to the people and have a better grasp of the problem.

SEE THREAT TO PEOPLE'S HEALTH

"The American doctors have made eminent progress in caring for the health of our people. Medical organizations and private hospital groups are making substantial progress toward the goal of providing adequate medical and hospital care for all.

"In view of this record, I regard the proposals emanating from this administration for governmental intervention between the doctor and his patient, as an undeserved affront to a loyal and admirable profession and a distinct threat to the future health of our people.

"It is these meddlesome activities in so many spheres that properly belong to the states or to the people themselves that have led to the multiplicity of government agencies which are unsupervised and uncontrolled and which it is impossible to supervise or control. These virtually autonomous agencies were set loose upon the people with unlimited funds and the people in pursuing their peace-time affairs were sorely beset in trying to accommodate themselves to the disorder. It was one of the significant reasons why we failed to achieve a sound, economic recovery before the war.

"Please do not misunderstand me. Government must be responsive to the needs of social progress in every field. It must continue to be. Human welfare means more than good intentions and material help. It must promote education, health, and public welfare. But it must leave to individual human beings a full measure of control over their own destiny. Governmental management and regimentation inevitably lead to national chaos and disorder".

Large Fund Left by Mrs. Prentiss For Medical and Health Programs

Funds estimated at more than $8,000,000, have been left in trust by the late Mrs. Elizabeth Severance Prentiss, Cleveland, for the advancement of medicine, health, art, music, education and religion through institutions in which she was interested for many years before her death, January 4. Thirty-seven per cent of the assets are to support the Elizabeth Severance Prentiss Foundation, the objectives of which are to promote medical and surgical research, to initiate and further activities in the field of public health, to aid hospitals and health institutions in Cuyahoga County, to improve methods of hospital administration and to aid in support of plans to make hospitalization and medical care available to all people, especially those of low income. Among other beneficiaries of the trust fund are Western Reserve University, Cleveland Museum of Health and Hygiene, and Allen Memorial Medical Library.

In establishing the foundation Mrs. Prentiss expressed the request that at least 50 per cent of the income derived from her foundation gifts be paid to St. Luke's Hospital Association as long as its standards of service and administration are on a level prevailing in a first class hospital. She also directed that most of the foundation activities be carried on in Ohio and that at least 60 per cent of all disbursement be made within the state.

CONVENTION INFORMATION and OFFICIAL PROGRAM

NINETY-EIGHTH ANNUAL MEETING
OHIO STATE MEDICAL ASSOCIATION
Neil House, Columbus • May 2, 3 and 4, 1944

TIME AND PLACE—Tuesday, Wednesday and Thursday, May 2, 3 and 4, 1944, The Neil House, Columbus, Ohio. The program will be presented in accordance with Columbus (railroad) time. The time schedule for the various sessions will be enforced, barring unforeseen developments. Those attending should make every effort to assemble at the times indicated.

REGISTRATION—Registration Headquarters, Junior Ballroom, Mezzanine Floor. Open daily to 5:30 P. M. Admission to all sessions by badge only, secured at Registration Headquarters. Registration privileges extended to all members of the Ohio State Medical Association; physicians from other states who are members of their respective state medical societies; medical students, interns, residents, nurses, health workers; and others attending the meeting as guests of a member of the Ohio State Medical Association and presented by them to the Registration Headquarters. Each member should have his 1944 State Association membership card available for presentation at time of registration. No registration fee.

HOUSE OF DELEGATES—Red Room, Mezzanine Floor. First session, 3:30 P.M., Tuesday, May 2; second session, 1:00 P. M. Thursday, May 4. Only delegates may participate in proceedings but members of the State Association are privileged to attend both business sessions.

TECHNICAL EXHIBITS—Mezzanine Lounge and Junior Ballroom. Open daily to 7:00 P.M. Sixty-two displays of products, equipment, books, etc. All members should make a special effort to see each and every display and to become acquainted with firm representatives. See program for special intermissions to permit members to view the exhibits.

QUIZ-DISCUSSION SESSIONS—This popular feature of the 1942 Annual Meeting will be repeated this year on Wednesday, May 3, 4:00 to 5:00 P. M. Guest speakers as well as selected Ohio physicians will be present at the six Quiz-Discussion Sessions to answer questions submitted by members. If possible, questions should be submitted in writing, in advance. See the Official Program for blank for submitting question, fields to be covered by the sessions, and names of those selected to answer questions. These informal sessions offer an opportunity for members to get advice and information on specific questions arising in every-day practice from authorities in the various fields and specialties.

WOMAN'S AUXILIARY—Convention Headquarters, Deshler-Wallick Hotel, High and Broad Streets, Tuesday, Wednesday and Thursday, May 2, 3 and 4.

ANNUAL DINNER—Main Ballroom, Mezzanine Floor, Neil House, Wednesday, May 3, 7:00 P. M. Tickets for the Annual Dinner will be on sale at the Registration Headquarters. Members are urged to purchase their tickets when registering as it will be necessary to give the hotel a guarantee of plates to be served. See program for complete details of dinner session. Note that the dinner will be on the second evening of the three days' meeting.

SPECIAL TELEPHONE SERVICE—A special telephone service for physicians attending the meeting will be maintained through the courtesy of the Columbus Academy of Medicine and the Columbus Bureau of Medical Economics. Those wishing to have emergency calls relayed to them while they are attending the meeting should arrange to have such calls routed through the Academy number, ADams 8101.

Official Program

Tuesday, May 2

3:30 P. M.

Red Room, Mezzanine Floor

FIRST SESSION, HOUSE OF DELEGATES

8:00 P. M.

Main Ballroom, Mezzanine Floor

FIRST GENERAL SESSION

Dr. Charles A. Doan, Columbus, Chairman, Committee on Scientific Work, presiding.

FUNCTIONAL AND ORGANIC DISEASES OF GASTRO-INTESTINAL TRACT

Physiological and Medical Considerations

Dr. Andrew C. Ivy, Chicago,
Nathan Smith Davis Professor of Physiology, Northwestern University School of Medicine.

Surgical Considerations

Dr. Arthur W. Allen, Boston,
Lecturer in Surgery, Harvard Medical

School, Boston; and Chief, East Surgical Service, Massachusetts General Hospital.

10:00 P.M.

Hall of Mirrors, Deshler-Wallick Hotel

WOMAN'S AUXILIARY RECEPTION

All members of the Ohio State Medical Association will be guests of the Auxiliary at this traditional informal reception.

Wednesday, May 3

9:30 A. M.

Main Ballroom, Mezzanine Floor

SECTION ON EYE, EAR, NOSE AND THROAT

Dr. W. H. Evans, Youngstown.....Chairman
(Now on active duty, Lt. Comdr., M.C., U.S.N.R.)
Dr. H. C. Rosenberger, Cleveland.....Secretary

Minutes Business

Selection of Nominating Committee

9:45 to 10:10

EXTERNAL DISEASES OF THE EYE

Dr. Albert D. Frost, Columbus.

General Discussion—10 minutes. (Each discussant limited to 3 minutes.)

10:10 to 10:35

ACUTE OBSTRUCTIVE DYSPNEA

Dr. Homer V. Weaver, Canton.

General Discussion—10 minutes. (Each discussant limited to 3 minutes.)

10:35 to 11:05

CINE-BRONCHOSCOPY — KODACHROME VISUALIZATION OF ENDOBRONCHIAL PATHOLOGY

Dr. Paul Holinger, Chicago,
Assistant Professor of Laryngology,
University of Illinois College of Medicine.

11:05 to 11:30

VERTIGO—PRACTICAL CONSIDERATIONS

Dr. Paul M. Moore, Cleveland.

No General Discussion. The 10-minute discussion period will be used by Dr. Henry M. Goodyear, Cincinnati, for a presentation, "Surgical Approach to the Labyrinth in Meniere's Disease."

11:30 to 11:55

INFECTIOUS LARYNGO-TRACHEO-BRONCHITIS

Dr. Robert E. Howard, Cincinnati.

General Discussion—10 minutes. (Each discussant limited to 3 minutes.)

11:55 to 12:05

Election of Officers

ADJOURNMENT FOR INSPECTION OF EXHIBITS

Wednesday, May 3

9:30 A. M.

Red Room, Mezzanine Floor

SECTION ON NERVOUS AND MENTAL DISEASES

Dr. Howard Fabing, Cincinnati.....Chairman
(Now on active duty, Major, M.C., A.U.S.)
Dr. J. M. Wittenbrook, Cleveland.....Secretary

Minutes Business

Selection of Nominating Committee

9:45 to 10:10

PROGRESS IN NEURO-SURGICAL TREATMENT RESULTING FROM WAR EXPERIENCES

Dr. W. J. Gardner, Cleveland.

Discussion—10 minutes.

10:10 to 11:00

CRITERIA FOR RECOGNITION OF THE PSYCHIATRICALLY UNFIT (Panel Discussion)

Moderator: Dr. Henry Schumacher, Cleveland.

Discussants: Member of Staff, Fletcher General Hospital, Cambridge; Col. Cleve C. Odom, Darnall General Hospital, Danville, Kentucky; Dr. John Romano, Cincinnati; Capt. Irwin Mason, Induction Station, Cleveland.

11:00 to 11:50

TREATMENT OF MENTAL ILLNESS DEVELOPED DURING ENVIRONMENTAL STRESSES AND STRAINS (Panel Discussion)

Moderator: Dr. George T. Harding, Columbus.

Discussants: Major Henry Luidens, Patterson Field; Col. Cleve C. Odom, Darnall General Hospital, Danville, Kentucky; Dr. John Romano, Cincinnati.

11:50 to 12:00

Election of Officers.

ADJOURNMENT FOR INSPECTION OF EXHIBITS

Wednesday, May 3

9:30 A. M.

Victory Room, Lobby Floor

SECTION ON PEDIATRICS

Dr. Earl H. Baxter, Columbus.....Chairman
Dr. M. L. Ainsworth, Columbus.....Secretary

Minutes Business

Selection of Nominating Committee

9:45 to 10:10

STILL'S DISEASE

Dr. Sterling H. Ashmun, Dayton.

General Discussion—10 minutes. (Each discussant limited to 3 minutes.)

10:10 to 10:35

DENTISTRY IN PEDIATRICS

Dr. L. S. Pettit, Columbus,
Assistant Professor, Ohio State University College of Dentistry; and Chairman, Department of Children's Dentistry.

General Discussion—10 minutes. (Each discussant limited to 3 minutes.)

10:35 to 11:00

MENINGOCOCCUS MENINGITIS

Dr. Frank Stevenson, Cincinnati.

General Discussion—10 minutes. (Each discussant limited to 3 minutes.)

11:00 to 11:25

INFLUENZAL MENINGITIS

Dr. O. W. Hosterman, Columbus.

General Discussion—10 minutes. (Each discussant limited to 3 minutes.)

11:25 to 11:50

THE DIAGNOSIS OF VISUAL SKILLS IN EARLY CHILDHOOD

Dr. Samuel Renshaw, Columbus,
Professor of Experimental Psychology, Ohio State University.

General Discussion—10 minutes. (Each discussant limited to 3 minutes.)

11:50 to 12:00

Election of Officers

ADJOURNMENT FOR INSPECTION OF EXHIBITS

Wednesday, May 3

9:30 A.M.

Birch Room, Mezzanine Floor

ANNUAL MEETING OF OHIO STATE RADIOLOGICAL SOCIETY

Dr. E. C. Baker, Youngstown.....President
Dr. E. R. Bader, Cincinnati.....Secretary

9:30 to 10:00

VENOGRAPHY OF THE LOWER EXTREMITIES

Dr. E. C. Baker, Youngstown,
Attending Roentgenologist, Youngstown Hospital.

10:00 to 10:30

BRONCHO-PNEUMONIA OF THE ATYPICAL TYPE: RELATION OF THE RADIOGRAPHIC FINDINGS TO THE CLINICAL EVIDENCE

Dr. C. E. Hufford, Toledo,
Associate Roentgenologist, St. Vincent's Hospital, Toledo.

10:30 to 11:00

OPERABILITY VERSUS CURABILITY OF CANCER OF THE BREAST

Dr. U. V. Portmann, Cleveland,
Director, Department of Therapeutic Radiology, Cleveland Clinic Foundation.

11:00 to 11:30

DIVERTICULITIS OF THE DISTAL COLON

Dr. H. G. Reineke, Cincinnati,
Assistant Professor of Radiology, University of Cincinnati College of Medicine.

11:30 to 12:00

THE ARC-WELDER'S LUNG

Dr. Jean Groh, Cleveland,
Roentgenologist, Lutheran Hospital, Cleveland.

12:00 Noon

Luncheon to be followed by executive session.

Wednesday, May 3

9:30 A. M.

Garden Room, Mezzanine Floor

ANNUAL MEETING OF OHIO SOCIETY OF ANESTHETISTS

Dr. James H. Bennett, Cincinnati.....President
Dr. B. B. Sankey, Cleveland.....Secretary

9:30 to 9:45

PRESIDENTIAL ADDRESS

Dr. James H. Bennett, Cincinnati,
Department of Anesthesia, Cincinnati General Hospital.

9:45 to 10:15

ANESTHESIA IN THORACIC SURGERY

Dr. Norris E. Lenahan, Columbus,
Department of Anesthesia, University Hospital, Columbus.

10:15 to 10:45

THE USE OF CURARE IN ANESTHESIA

Dr. R. J. Whitacre and Dr. A. J. Fisher, Cleveland,
Department of Anesthesia, Huron Road Hospital, Cleveland.

10:45 to 11:45

FACTORS THAT INFLUENCE THE SUCCESS OF AN ANESTHETIC ADMINISTRATION

Dr. Noel Gillespie, Madison, Wisconsin,
Assistant Professor of Anesthesia, University of Wisconsin.

11:45 to 12:00

CASE REPORT OF CIRCULATORY FAILURE

Dr. B. B. Sankey, Cleveland,
Department of Anesthesia, St. Luke's Hospital, Cleveland.

Wednesday, May 3

12:00 Noon

Deshler-Wallick Hotel

ANNUAL MEETING OF THE OHIO CHAPTER OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS

Dr. Myron D. Miller, Columbus.....President
Dr. Elmer E. Kirkwood, Youngstown....Secretary

LUNCHEON MEETING

TREATMENT OF TUBERCULOUS EMPYEMA

Dr. Karl P. Klassen and Dr. Geo. M. Curtis, Columbus.

QUESTION BOX

Dr. Louis Mark, Columbus.

X-RAY CONFERENCE

Dr. D. W. Heusinkveld, Cincinnati.

12:00 Noon

Class and Fraternity Luncheons.

Wednesday, May 3

2:30 P. M.

Main Ballroom, Mezzanine Floor

SECOND GENERAL SESSION

Dr. Louis G. Herrmann, Cincinnati, Member, Committee on Scientific Work, presiding.

CIRRHOSIS OF THE LIVER

Dr. Andrew C. Ivy, Chicago,
Nathan Smith Davis Professor of Physiology, Northwestern University School of Medicine.

3:00 to 3:30

GALLBLADDER DISEASES

Dr. Arthur W. Allen, Boston,
Lecturer in Surgery, Harvard Medical School, Boston; and Chief, East Surgical Service, Massachusetts General Hospital.

3:30 to 4:00

RECESS FOR INSPECTION OF EXHIBITS

Wednesday, May 3

4:00 to 5:00

QUIZ-DISCUSSION SESSIONS

MEDICINE, INCLUDING TROPICAL MEDICINE, PSYCHIATRY AND OCCUPATIONAL DISEASES

Main Ballroom, Mezzanine Floor

Dr. Homer D. Cassel, Dayton, Moderator
Dr. Andrew C. Ivy, Chicago, guest speaker
Dr. Russell L. Haden, Cleveland
Dr. Marion A. Blankenhorn, Cincinnati
Dr. William M. German, Cincinnati
Dr. Bruce K. Wiseman, Columbus
Dr. John Romano, Cincinnati

SURGERY, INCLUDING ORTHOPEDIC AND INDUSTRIAL SURGERY

Red Room, Mezzanine Floor

Dr. Louis G. Herrmann, Cincinnati, Moderator
Dr. Arthur W. Allen, Boston, guest speaker
Dr. Joseph A. Freiberg, Cincinnati
Dr. George M. Curtis, Columbus
Dr. Edward J. McGrath, Cincinnati
Dr. John W. Holloway, Cleveland
Dr. W. A. Altemeier, Cincinnati

EYE, EAR, NOSE AND THROAT

Garden Room, Mezzanine Floor

Dr. Fred W. Dixon, Cleveland, Moderator
Dr. Paul Holinger, Chicago, guest speaker
Dr. Horace E. Mitchell, Lakewood
Dr. M. Paul Motto, Cleveland
Dr. Henry Goodyear, Cincinnati
Dr. A. D. Frost, Columbus

PEDIATRICS

Birch Room, Mezzanine Floor

Dr. Earl H. Baxter, Columbus, Moderator
Dr. A. A. Weech, Cincinnati
Dr. James G. Kramer, Akron
Dr. Sterling H. Ashmun, Dayton

OBSTETRICS AND GYNECOLOGY

Walnut Room, Mezzanine Floor

Dr. Tom F. Lewis, Columbus, Moderator
Dr. Charles W. Pavey, Columbus
Dr. Martin W. Diethelm, Toledo
Dr. Wilbur A. Ricketts, Dayton

HYGIENE AND PUBLIC HEALTH

Coral Room, Mezzanine Floor

Dr. R. H. Markwith, Columbus, Moderator
Dr. Carl A. Wilzbach, Cincinnati
Dr. W. D. Bishop, Greenville
Dr. Christopher Leggo, Columbus
Dr. R. E. Heering, Columbus
Dr. Susan P. Souther, Columbus

Wednesday, May 3

7:00 P. M.

Main Ballroom, Mezzanine Floor

ANNUAL DINNER

(Informal)

Dr. C. C. Sherburne, Columbus, President, Ohio State Medical Association, toastmaster.

Introduction of Incoming President, Dr. L. Howard Schriver, Cincinnati, and Members of The Council.

Presentation of Past-President's Gavel: Dr. Edward J. McCormick, Toledo.

Address: "Britain in Wartime", Hon. Grove Patterson, editor, *The Toledo Blade*.

Thursday, May 4

9:30 A. M.

Main Ballroom, Mezzanine Floor

THIRD GENERAL SESSION

Dr. Earl W. Huffer, Toledo, Member, Committee on Scientific Work, presiding.

PREVENTION OF INDUSTRIAL DERMATOSES

Dr. Christopher Leggo, Columbus,
Chief of Division of Industrial Hygiene, Ohio Department of Health.

10:00 to 10:30

HYPERBILIRUBINEMIA IN THE NEWBORN

Dr. A. A. Weech, Cincinnati,
B. K. Rachford Professor of Pediatrics, University of Cincinnati College of Medicine, and Director, Department of Pediatrics.

10:30 to 11:00

RECESS FOR INSPECTION OF EXHIBITS

11:00 to 11:30

TREATMENT OF FRACTURES AS RELATED TO FUNCTIONAL RECOVERY

Dr. Edward Harlan Wilson, Columbus,
Professor of Orthopedic Surgery, Ohio State University College of Medicine.

11:30 to 12:00

FATIGUE

Dr. Anton J. Carlson, Chicago,
Professor Emeritus of Physiology, University of Chicago.

Thursday, May 4

1:00 P. M.

Red Room, Mezzanine Floor

SECOND AND FINAL SESSION, HOUSE OF DELEGATES

1:30 P. M.

Main Ballroom, Mezzanine Floor

FOURTH GENERAL SESSION

Dr. Fred W. Dixon, Cleveland, Member, Committee on Scientific Work, presiding.

Members Urged to Purchase Annual Dinner Tickets When Registering; Mr. Grove Patterson To Be Guest Speaker

THE Ohio State Medical Association is fortunate in having been able to secure the Hon. Grove Patterson, editor of *The Toledo Blade*, as the guest speaker for its Annual Dinner on Wednesday evening, May 3, during the 98th Annual Meeting, May 2, 3, and 4, Neil House, Columbus. Mr. Patterson's subject will be, "Britain in Wartime".

Tickets for the Annual Dinner will be sold at the Registration Headquarters. Members are urged to purchase their dinner tickets when they register. Those who delay will be unable to obtain admission to the dinner as war restrictions will make it necessary for the State Association to discontinue the sale of tickets five or six hours prior to the time of the dinner and to limit the number of dinner guests to the seating capacity of the Main Ballroom—approximately 475. Therefore, sale of tickets will be on a first-come-first-served basis, only 475 tickets will be sold and only those with tickets will be served.



Mr. Grove Patterson
Editor, *Toledo Blade*

Mr. Patterson's address will be primarily a review of his experiences and what he learned in the Fall of 1943 during a month's tour of the British Isles at the special invitation of the British Ministry of Information.

While overseas, Mr. Patterson was given an unusual opportunity to talk privately with some of the highest officers of the British Army, Navy and Air Force; outstanding public officials, including Prime Minister Winston Churchill, Foreign Secretary Anthony Eden, Field Marshal Jan Christian Smuts and representatives of some of the exiled governments; prominent industrial, labor and civilian leaders; and "rank and file" Britishers.

One of Ohio's outstanding civic leaders, Mr. Patterson also is one of the nation's best-informed citizens on international relations because of his frequent visits to foreign countries. After attending the Disarmament Conference in Geneva, Switzerland, in 1932, Mr. Patterson visited Rome, where he interviewed Mussolini. He then visited the Balkans, Russia and the Scandinavian Countries.

In 1933, Mr. Patterson returned to Europe, touring 12 countries and spending a month in Russia. The following year he visited Spain and was decorated by the Spanish Government with the Order of Isabella, highest honor within the gift of that government. Again in 1937, Mr. Patterson crossed the Atlantic, attending the coronation ceremonies in London and traveling through 14 European countries. He also holds a decoration from the Polish Government—the Gold Cross of Merit—conferred on him in 1938.

MOTION PICTURE—KNOWLESI MALARIA IN RHESUS MONKEYS

Dr. Melvin H. Knisely, Chicago, Illinois,
Assistant Professor of Anatomy, University of Chicago; and Visiting Professor, University of Tennessee Medical School.

Dr. Knisely and his associates during the past three years have been making important contributions to the understanding of the pathologic physiology of malaria, its symptoms and its treatment, through cinematographic color recordings of experimentally induced malaria infection in monkeys under controlled conditions. The importance of the circulation and the role of auto-agglutination of parasitized cells in the production of symptoms are graphically demonstrated. The way in which both quinine sulfate and atabrine accomplish improvement in malaria is illustrated. Application of the principles established in this study from malaria to a rather wide variety of other conditions in which shock and cardiovascular pathology exist is pointed out. The methods and results of this study are spectacular. Members of the Ohio State Medical Association are exceedingly fortunate to be able to have this work presented by Dr. Knisely in person.

2:30 to 3:15

MALARIA AND ITS TREATMENT. A NEW APPROACH; WITH IMPLICATIONS AND APPLICATIONS TO OTHER PATHOLOGIC STATES

Dr. Melvin H. Knisely, Chicago, Illinois.

3:15 to 3:45

CURRENT NEUROPSYSCHIATRIC PROBLEMS

Dr. John Romano, Cincinnati,
Professor of Psychiatry, University of Cincinnati College of Medicine.

3:45 to 4:45

THE DYSENTERIES

Dr. Edward L. Turner, Nashville, Tenn.,
President and Professor of Medicine, Meharry Medical College.

Woman's Auxiliary Convention

Deshler-Wallick Hotel, May 2, 3, and 4, 1944

ALL GENERAL SESSIONS IN THE HALL OF MIRRORS

MRS. JOHN EARL BRIGGS, COLUMBUS, GENERAL CHAIRMAN

Tuesday, May 2

10:00 A.M.

REGISTRATION

12.30 P.M.

BOARD OF DIRECTORS' LUNCHEON AND MEETING OF BOARD

3:30 P.M.

GENERAL SESSION OF AUXILIARY

7:00 P.M.

"LITTLE DINNERS", FOLLOWED BY ROUND-TABLE DISCUSSIONS

10:00 P.M.

RECEPTION, HALL OF MIRRORS, FOR MEMBERS OF OHIO STATE MEDICAL ASSOCIATION

Wednesday, May 3

9:30 A.M.

GENERAL SESSION OF AUXILIARY

1:00 P.M.

LUNCHEON HONORING MRS. EBEN J. CAREY, WAUWATOSA, WISCONSIN, PRESIDENT, WOMAN'S AUXILIARY, AMERICAN MEDICAL ASSOCIATION.

ADDRESS: Mrs. Carey.

ADDRESS: Dr. C. C. Sherburne, Columbus, president, Ohio State Medical Association.

ADDRESS: Dr. L. Howard Schriver, Cincinnati, president-elect, Ohio State Medical Association.

Thursday, May 4

9:30 A.M.

GENERAL SESSION OF AUXILIARY

1:00 P.M.

LUNCHEON HONORING MRS. R. S. FIDLER, COLUMBUS, PRESIDENT-ELECT, WOMAN'S AUXILIARY, OHIO STATE MEDICAL ASSOCIATION.

3:00 P.M.

POST-CONVENTION BOARD MEETING

OFFICERS, DIRECTORS AND COMMITTEE CHAIRMEN

President—Mrs. J. L. Stevens, Mansfield

President-elect—Mrs. R. S. Fidler, Columbus

Past-president—Mrs. Dale P. Osborn, Cincinnati

Vice-president—Mrs. Frank Siedenburg, Portsmouth

Secretary—Mrs. George Wilcoxon, Alliance

Treasurer—Mrs. Theodore Vinke, Cincinnati

Directors—Mrs. Maurice Hoyt, Hillsboro; Mrs. Kenneth Lowry, Troy; Mrs. Claude Lingenfelter, Bucyrus; Mrs. Paul Holmes, Toledo; Mrs. I. F. Weidlein, Cleveland; Mrs. L. L. Frick, North Canton; Mrs. C. J. Miller, New Philadelphia; Mrs. J. F. Weber, Marietta; Mrs. William Singleton, West Portsmouth; Mrs. Julius Shamansky, Mt. Vernon; Mrs. Leonard Hautzenroeder, Mansfield.

Finance Committee Chairman—Mrs. Dale Osborn, Cincinnati

Publicity Committee Chairman—Mrs. C. I. Stafford, Oxford

Hygeia Committee Chairman—Mrs. Clyde Fitch, Portsmouth

Program Committee Chairman—Mrs. Murray E. Goodrich, Toledo

Legislative Committee Chairman — Mrs. D. W. Heusinkveld, Cincinnati

Public Relations Committee Chairman — Mrs. Charles R. Meek, Lorain

Historical Committee Chairman—Mrs. Howard Dittrick, Cleveland

Organization Committee Chairman—Mrs. R. S. Fidler, Columbus

Technical Exhibitors

Mezzanine Lounge and Junior Ballroom
Open Daily to 7 P. M.

	Booth
A. S. Aloe Company St. Louis, Mo.	26
Baker Laboratories, The Cleveland, Ohio	7
Bilhuber-Knoll Corporation Orange, N. J.	39
Borden Company, The New York, N. Y.	20
Bowman Bros. Drug Company, The Canton, Ohio	5
Burke X-Ray Sales Company Cleveland, Ohio	16
Burroughs Wellcome & Co., U. S. A., Inc. New York, N. Y.	40
Camel Cigarettes New York, N. Y.	27-28
Cameron Surgical Specialty Co. Chicago, Ill.	52
Camp & Company, S. H. Jackson, Mich.	38
Carnation Company Oconomowoc, Wisc.	48
Ciba Pharmaceutical Products, Inc. Summit, N. J.	59
Coca-Cola Company Atlanta, Ga.	29
Columbus Hospital Supply Co. Columbus, Ohio	58
Denver Chemical Mfg. Co., The New York, N. Y.	47
DePuy Manufacturing Company Warsaw, Ind.	57
Electro Medical Equipment Co. Cleveland, Ohio	56
Endo Products, Inc. Richmond Hill, N. Y.	18
General Electric X-Ray Corp. Chicago, Ill.	3
Gerber Products Company Fremont, Mich.	37
Heinz Company, H. J. Pittsburgh, Pa.	53
'Junket' Folks, The Little Falls, N.Y.	22
Kelley-Koett Mfg. Co., Inc., The Covington, Ky.	14
Kellogg Company, The Battle Creek, Mich.	35
Lea and Febiger Philadelphia, Pa.	19
Lederle Laboratories, Inc. New York, N. Y.	49
Liebel-Flarsheim Co. Cincinnati, Ohio	55
Lilly & Company, Eli Indianapolis, Ind.	61
Lippincott Co., J. B. Philadelphia, Pa.	17
Maltine Company, The New York, N. Y.	43
Mead Johnson & Company Evansville, Ind.	33-34
Medical Protective Co., The Ft. Wayne, Ind.	6
Merrell Company, Wm. S., The Cincinnati, Ohio	30
M & R Dietetic Laboratories, Inc. Columbus, Ohio	54
Mosby Company, C. V., The St. Louis, Mo.	51
Parke, Davis & Company Detroit, Mich.	13
Pelton & Crane Co., The Detroit, Mich.	32
Pet Milk Sales Corporation St. Louis, Mo.	31
Philip Morris & Co., Ltd., Inc. New York, N. Y.	62
Pitman-Moore Company Indianapolis, Ind.	23
Saunders Company, W. B. Philadelphia, Pa.	41
Schering Corporation Bloomfield, N. J.	50
Schuemann-Jones Company, The Cleveland, Ohio	4
Searle & Company, G. D. Chicago, Ill.	42
Sharp & Dohme, Inc. Philadelphia, Pa.	36
Spencer Incorporated New Haven, Conn.	12
Squibb and Sons, E. R. New York, N. Y.	21
Stearns & Co., Frederick Detroit, Mich.	44-45
Warner & Company, Inc., William R. New York, N. Y.	24-25
Wendt-Bristol Company, The Columbus, Ohio	15
Westinghouse Electric & Manufacturing Co. Pittsburgh, Pa.	1
White Laboratories, Inc. Newark, N. J.	2
Winthrop Chemical Company, Inc. New York, N. Y.	60
Wyeth & Bro., Inc., John Philadelphia, Pa.	8-9 10-11
Zimmer Manufacturing Company Warsaw, Ind.	46

QUESTIONS . . . . . .

● Which you want answered at the quiz-discussion sessions at the 1944 Annual Meeting of The Ohio State Medical Association, May 2, 3 and 4, Neil House, Columbus, should be submitted immediately.

Turn to Page 342, This Issue, for Personnel of Panels Which Will Answer Questions at the Quiz-Discussion Sessions on May 3

USE THIS BLANK FOR YOUR QUESTION

Ohio State Medical Association
79 East State Street
Columbus 15, Ohio

I expect to attend the Quiz-Discussion Session on.....
(See Page 342 for List

.....on May 3, at the 1944 Annual Meeting, Columbus; and
of Quiz-Discussion Sessions)
would like to have the following question answered by the panel discussants at that Session:

Question:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Ohio's Silicosis Record Analyzed In Recent Commission Report

Since silicosis was made a compensable occupational disease on July 31, 1937, a total of 1,366 claims for compensation for this disease have been filed with the Ohio Industrial Commission, according to the *Ohio Industrial Commission Monitor*. Out of this number, 629 claims were allowed, 662 disallowed and 75 are still pending.

Analysis of the claims held compensable shows that 341 originated in foundries. The majority of these, 190 cases, occurred in iron foundries, 80 in steel foundries and 71 in non-ferrous metal foundries.

A total of 209 allowed claims are charged to the ceramics industry. The principal source of these was in the manufacture of tableware, with 64 claims. Floor and wall tile developed 51 cases, glass house refractories 17, electric insulators 18, silica sand and diatomaceous earth 11, silica brick 10, insulating brick 8, stoneware products 8, sanitary ware 8, enamels 5, glassware 5, building brick and tile 2 and fire brick 2.

Thirty-eight of the approved claims were filed by employees in the cut stone industry. Monument making accounted for 27, building stone 7 and quarries 4.

Fourteen of the allowed claims were due to polishing, buffing and grinding of iron and steel, 13 were due to bricklaying, 3 to exposure to silica in coal mines and 11 from miscellaneous causes.

Following is the record of claims for silicosis during the past four years.

	1940	1941	1942	1943
Claims filed	249	270	278	222
Claims allowed	83	132	145	140
Claims disallowed	113	118	121	145

The claims allowed over the four year period were distributed among the various classifications as follows:

	1940	1941	1942	1943
Foundries	41	69	81	78
Ceramics	34	45	38	50
Cut Stone	4	9	11	5
Coal Mining	1	2	0	0
Grinding, etc.	3	2	5	3
Bricklayers	—	—	—	3
Miscellaneous	—	5	10	1

As evidence of the progress being made in the clearing up of pending claims, the record shows that only 75 cases were pending December 31, 1943, as compared with 138 on the same date in 1942.



Walker's A-D DROPS

SOMETHING NEW! Natural esters of vitamin A (distilled from fish liver and vegetable oils), plus activated ergosterol in a vehicle of refined corn oil.

Advantages of this new product are:

1. Practically no "fishy" odor or taste.
2. Excellent stability.
3. Each DROP supplies
   Vitamin A—2,000 U. S. P. Units
   Vitamin D— 300 U. S. P. Units
4. It's good—it's flavored with cinnamon.
5. It's "Council Accepted."

From infancy through childhood—for good "A-D" insurance—prescribe WALKER'S A-D DROPS.

WALKER
VITAMIN PRODUCTS, INC.
MOUNT VERNON • NEW YORK

Last Call for Hotel Reservations for Annual Meeting, Tuesday, Wednesday and Thursday, May 2, 3 and 4

THIS is your last chance to make hotel reservations for the Ninety-Eighth Annual Meeting of the Ohio State Medical Association, Tuesday, Wednesday and Thursday, May 2, 3 and 4, at Columbus.

You know what type of accommodations you want. The best way to insure your obtaining those accommodations is to make a request for reservations—**immediately**—to the hotel of your choice. Address your request directly to the management of the hotel selected.

Check the accompanying list of Columbus hotels, their locations and rates. Make your choice! Fill in the blank accordingly! Mail it **now**!

NAME AND LOCATION	No. of Rooms	Single	Double	Double Twin Beds	Suites
NEIL HOUSE (Headquarters Hotel) 35 South High St.	665	$4.50-7.00	$5.50-9.00	$6.50-11.00	Rates on request
DESHLER-WALLICK Broad and High Sts.	1000	3.50-8.80	5.50-11.00	6.50-13.30	$8.80 to $26.40
FORT HAYES 31 W. Spring St.	350	3.00 and up	4.50 and up	5.00 and up	7.00-18.00
CHITTENDEN High and Spring Sts.	275	2.50-3.00	3.00-4.00	3.50-6.00	
SENECA 361 E. Broad St.	250	2.50-3.50	3.75-5.00	5.00-5.50	3.75 to 8.00 (single) 5.50 to 10.00 (double)
SOUTHERN High and Main Sts.	250	2.50-3.00	3.50-4.50	4.00-4.50	
VIRGINIA Third and Gay Sts.	150	2.20 and up	3.30 and up	4.40 and up	
BROAD-LINCOLN 631 E. Broad St.	140	2.00 and up plus 10%	3.00 and up plus 10%	4.50 and up plus 10%	3.50 and up plus 10%

HOTEL RESERVATION BLANK

Mail this coupon to hotel selected

Manager_____ Hotel, Columbus, Ohio.

You are requested to reserve the following accommodations during the period of the Ninety-Eighth Annual Meeting of the Ohio State Medical Association, May 2, 3 and 4, 1944, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double room with bath Price:_____

☐ Twin Bed Room with bath ☐ Suite

Arriving May_____ at_____ A.M.____ _____ P.M.

PLEASE VERIFY MY RESERVATION.

Name _____

Address _____

_____



THE SUNSET YEARS AND *Adequate Nutrition*

As the degenerative processes gain the upper hand during the last decade or two of life, profound changes occur in many metabolic mechanisms. The gastrointestinal tract for example becomes less tolerant of abuses, and difficulty is experienced in digesting some foods which formerly did not prove troublesome. The loss of vigor characteristic of senescence can easily be aggravated to a point of incapacitation if self-chosen eating habits are not altered to prevent nutritional deficiencies. For only by properly satisfying the nutritional requirements can adequate strength be maintained. Ovaltine is well tolerated by elderly persons. It supplies a wealth of nutrients which are readily metabolized and which are frequently lacking in the diets chosen during advanced years: biologically adequate protein, B complex vitamins, minerals, and vitamins A and D. Ovaltine is digested with ease, and its high content of diastatic enzyme makes it a valuable aid in the digestion of starchy foods. This delicious food-drink appeals to older persons, hence it can be included in their diet three times daily without meeting with resistance.

THE WANDER COMPANY, 360 NORTH MICHIGAN AVENUE, CHICAGO 1, ILLINOIS



Ovaltine

Three daily servings (1 ½ oz.) of New Improved Ovaltine provide:

	Dry Ovaltine	Ovaltine with milk*		Dry Ovaltine	Ovaltine with milk*
PROTEIN	6.0 Gm.	31.2 Gm.	VITAMIN A	1500 I.U.	2953 I.U.
CARBOHYDRATE	30.0 Gm.	62.43 Gm.	VITAMIN D	405 I.U.	480 I.U.
FAT	2.8 Gm.	29.34 Gm.	THIAMINE	.9 mg.	1.296 mg.
CALCIUM	.25 Gm.	1.104 Gm.	RIBOFLAVIN	.25 mg.	1.278 mg.
PHOSPHORUS	.25 Gm.	.903 Gm.	NIACIN	5.0 mg.	6.9 mg.
IRON	10.5 mg.	11.94 mg.	COPPER	.5 mg.	.5 mg.

*Each serving made with 8 oz. of milk; based on average reported values for milk.

Annual Reports of Standing and Special Committees of The Ohio State Medical Association

FOLLOWING are reports of committees of the Ohio State Medical Association which have transacted business since the 1943 Annual Meeting. These reports were prepared by the chairmen of the committees and will be submitted to the House of Delegates of the Association for consideration at the time of the 1944 Annual Meeting, May 2, 3 and 4, Columbus.

We urge all members to read these reviews of the more important activities of these committees. In doing so they will become more familiar with some of the vital questions which confront the profession and become better acquainted with the purposes, objectives, and activities of the State Association.

The Council desires to express its sincere appreciation to members of all committees for their work and loyal services during the past year. Without their help, The Council would have been severely handicapped in the transaction of its business.

Moreover, we wish to thank the officers and various committees of all County Medical Societies for their cooperation on many matters during the past 12 months. In the final analysis, the county societies are the pulse of the State Association—as the county societies go, so goes the State Association.

Uncertain and troublesome times are ahead. For that reason the medical profession must stand united. It must be alert. It must keep its local units strong and active. The State Association is merely a federation of local societies and is responsive to the will of the majority of its members—members of the local societies. What the State Association does will be in effect what the membership through the county societies would have it do.

The Council
Ohio State Medical Association

Committee on Public Relations and Economics

As usual the Committee on Public Relations and Economics has been called upon to assist The Council in studying some of the more important issues of vital interest to the medical profession of Ohio.

Action of the committee in recommending that the State Association refuse to approve the proposal of the U. S. Children's Bureau for an Emergency Maternity and Infant Care Program for the wives and children of enlisted men was approved by The Council. The action of the committee and of The Council on this question need not be discussed in detail here as a complete report was published in *The Journal* and distributed to all members of the Association. To date, the Association has not approved the program now in operation in Ohio and the question of participation is one which each physician has had to decide for himself. Approximately 13,000 applications for assistance under the program have been filed with the State Department of Health and approximately 2,500 physicians are participating. No doubt many of the physicians participating in the program feel that it is temporary in character and should be abandoned at the close of the war. Moreover, there is reason to believe that many of them are participating out of a spirit of patriotism.

PROGRAM IS UNSOUND

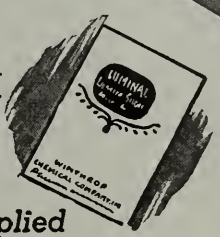
Your committee still feels that the program as promulgated by the Children's Bureau is unsound in principle. It believes that assistance should have been granted on the basis of need and that assistance should have been provided in the form of cash allotments to those requiring assistance. It believes that a more desirable method would have been for assistance to have been provided through existing voluntary agencies, cooperating with the medical profession, or if necessary through official local or state agencies already carrying on assistance programs for those in need. This was the recommendation of the committee in the first instance. The tactics which were used to block such plans are well known to all members.

The present program is a Federal medical program, written by a Federal bureau, controlled by a Federal bureau and financed with Federal funds. This particular program may be abandoned at the close of the war but it may have laid the ground work and set the pattern for even more extensive Federal medical programs in the post-war era. It is an outstanding example of rule and regulation by bureaucratic edict. The lessons to be learned are obvious. It is time for the Congress to recapture the power to make laws which has gradually been usurped by bureaus and commissions. It is time for those having a vital stake in governmental activities to realize that the time to prevent unsatisfactory programs from being foisted onto the public is when proposals asking the Congress to write blank checks

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to this or that bureau are being considered by the Congress. It is time for the medical profession to realize that it must become more vocal with the members of Congress on such matters and see that they are properly advised of the profession's views on medical and health questions. It is time for the governing body of the American Medical Association to realize the necessity of maintaining a properly manned office in Washington to assist in bringing about a closer relationship between the medical profession and the members of the Congress. It is time for many physicians to realize that they can not have their cake and eat it—governmental medicine can not be accepted by one hand and pushed into the discard with the other. It is time for the medical profession to realize that the real danger to the practice of medicine as a private enterprise lies in a multiplicity of independent programs such as that of the Children's Bureau, many of which are labeled "temporary" but which become permanent, flourishing projects.

THE WAGNER BILL

Those who are familiar with the provisions of the Wagner-Murray-Dingell Bill will readily understand that the implications of that proposal go far beyond the question of whether there shall or shall not be a Federal system of compulsory sickness insurance. The real issue involved is whether a system of state socialism at the Federal level shall or shall not be substituted for our present form of government.

Your committee studied the Wagner Bill and at the request of The Council, prepared a pamphlet, "No! The Wagner Bill Is Not the Answer!", pointing out the dangers of that proposal. This pamphlet was made available in quantities to all members of the State Association for distribution to the public. Several hundreds of thousands of these have been distributed. In addition, many physicians have addressed public gatherings on this measure. *The Journal* has endeavored to provide members with current data on the bill which can be used by members in their efforts to warn the public of its evils, and what its enactment would mean to the American people. Public opinion will play the major role in the final decision in the Congress on this or similar proposals. It is the responsibility of physicians to see that the public is properly informed—informed as to what its enactment would mean so far as the individual citizen is concerned, not what its effect would be on the medical profession. No action has been taken to date in the Congress on this proposal. Nevertheless, the profession should not be lulled into complacency. Now is the time for public education—the time for each physician to discuss the matter with his friends, neighbors and patients who in turn can express their views to their representatives in the Congress. It is recommended that those who have not obtained a supply of the Wagner Bill pamphlets get some immediately from the Columbus office and put them to work.

CONSTRUCTIVE PLANS SUGGESTED

Although your committee feels quite keenly that the Wagner Bill and its counterparts, past, present or future, would be detrimental to the health of the American people and destroy a system of medical practice which has provided innumerable blessings, it likewise believes that it would be the height of folly for the medical profession to even imply that there are no health problems waiting to be solved or that no improvements can be made in present methods of supplying medical and health services.

We feel many improvements can, and should, be made; that it is up to the medical profession to take the lead in providing the answers to some of our present-day health problems if it believes that the Wagner Bill and comparable proposals are not the answers. This point was stressed by the committee in one chapter of the pamphlet on the Wagner Bill, already referred to, and we desire to incorporate that chapter in this report. Under the heading "Let's Do the Job the Right Way", the committee said:

"A revolution, as proposed in the Wagner Bill, is not necessary to bring about further improvements in the health of 130,000,000 Americans.

"Safe and sane cooperation between private enterprise, the public and the government will do the job. Additional progress can be made by:

"Attacking the cause of unemployment and disability;

"Encouraging self-protection through thrift, savings and private insurance;

"Maintaining a sound, conservative Social Security Program, the efforts of which would be directed toward meeting contingencies which can not be met through private enterprise rather than in placing emphasis upon paying citizens for being unemployed and sick;

"Improving social, economic and working conditions generally;

"Expanding present programs for improvement of food, housing, recreation and other environmental conditions influencing health;

"Expanding present programs of health education;

"Improving present local and state programs providing medical and hospital care for the poor;

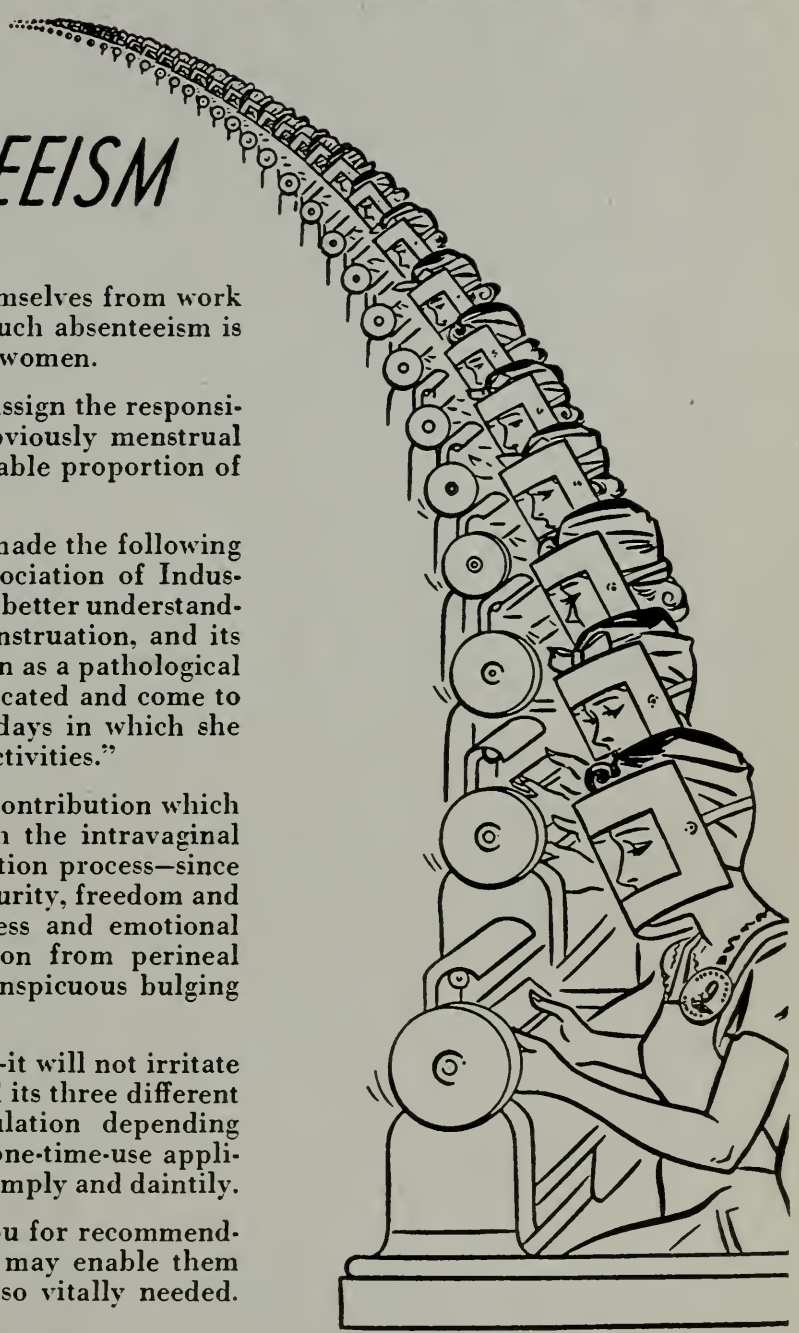
"Improving present programs providing care for and rehabilitation of the handicapped and permanently disabled;

"Expanding existing local and state public health programs to meet proven needs;

"Emphasizing the importance of financial responsibility on the part of local and state govern-

OBJECTIVE

REDUCTION OF FEMALE ABSENTEEISM



Statistics show that women absent themselves from work much more often than men; indeed, such absenteeism is said to be 50 per cent[1] higher among women.

Though available data do not clearly assign the responsibility for this marked differential, obviously menstrual inconveniences account for a considerable proportion of the days lost.

On this point Pommerenke[2] recently made the following observation before the American Association of Industrial Physicians and Surgeons: "With a better understanding of the purpose and nature of menstruation, and its recognition as physiological rather than as a pathological process, many a woman may be re-educated and come to regard the so-called difficult days as days in which she need not seriously curtail her usual activities."

Many physicians have discovered the contribution which *improved menstrual hygiene* (as with the intravaginal tampon Tampax) affords this reeducation process—since it provides such a welcome sense of security, freedom and poise by relieving the physical distress and emotional uncertainty caused by vulval irritation from perineal pads, or from olfactory offense, or conspicuous bulging under slacks or coveralls.

Tampax can be used easily and safely—it will not irritate delicate tissues nor block the flow. And its three different absorbencies permit individual regulation depending upon daily needs. Compressed into a one-time-use applicator, it may be inserted and removed simply and daintily.

Your patients should be grateful to you for recommending Tampax—and (in many cases) it may enable them to stay "on the job" where they are so vitally needed.

(1) Mod. Med., 11:130, 1943; (2) Ind. Med., 12:512, 1943

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ments—taxpayers generally—in those health activities which are the proper functions of government;

"Maintaining a major portion of administrative control in the hands of local officials and groups to insure a greater degree of efficiency, economy and responsibility;

"Accepting the assistance of the Federal Government in an advisory capacity but refusing to yield to Washington bureaucracy on matters which can and should be handled by private enterprise and by local and state governmental agencies;

"Expanding hospital facilities when and where needed but assuring administration will be unhampered by political domination;

"Expanding the number and coverage of voluntary medical and hospital service plans through which persons can budget the costs of sickness and the best of care can be made readily available to all."

NEED MEDICAL SERVICE PLANS

It should be noted that the committee has expressed itself as believing that one of the answers to some of the health problems confronting the public can be provided through the organization of voluntary pre-payment medical service plans under the terms of the Enabling Act, passed by the Ohio Legislature in 1941 and sponsored by the State Association. Unfortunately, no plan is as yet in operation in Ohio. It is the hope of your committee that definite action toward the establishment of a plan will be taken in the immediate future. The Council apparently feels likewise as it has offered the cooperation and financial support of the State Association in furthering an experimental medical service plan in Logan County, providing a satisfactory arrangement can be worked out by the Logan County Medical Society and the Ohio Land-Use Planning Commission. This commission which is interested in studying ways and means of improving social, economic and health conditions among the rural population had suggested the possibilities of setting up a medical service plan in Logan County on an experimental basis. On recommendation of the Committee on Public Relations and Economics, The Council voted its cooperation and offered to help finance the project. Studies are now under way and the matter is being considered by the Logan County Medical Society.

CONTACTS WITH VARIOUS AGENCIES

In addition to the major activities referred to, the Committee on Public Relations and Economics has met with representatives of the Army Emergency Relief and assisted them on various medical problems; conferred with representatives of the Federal government charged with the responsibility of seeing that medical and health services are provided for farm laborers imported into Ohio; considered questions in connection with the Ohio Physical Fitness and Recreation Program, suggesting that each county medical society organize a committee to handle this question at the local level; cooperated with the Women's Field Army, American Society for the Control of Cancer; established a working arrangement with the new Council on Medical Service and Public Relations of the American Medical Association; maintained its usual close contact with the Ohio General Assembly and with Ohio's members of the Congress which activities have been reviewed in *The Journal* and need not be analyzed in this report; and kept up its contacts with various state offices and agencies engaged in medical and health activities.

In conclusion, the committee desires to warn that many momentous questions will confront the profession during the ensuing year. For that reason, solidarity in our ranks is of vital importance. This is a general election year which means that our local public relations and legislative committees must be alert and active. Because many of our younger, active men are in the armed forces, the responsibilities of those who remain on the home front have multiplied and it is up to us to meet those challenges which will arise during the coming year.

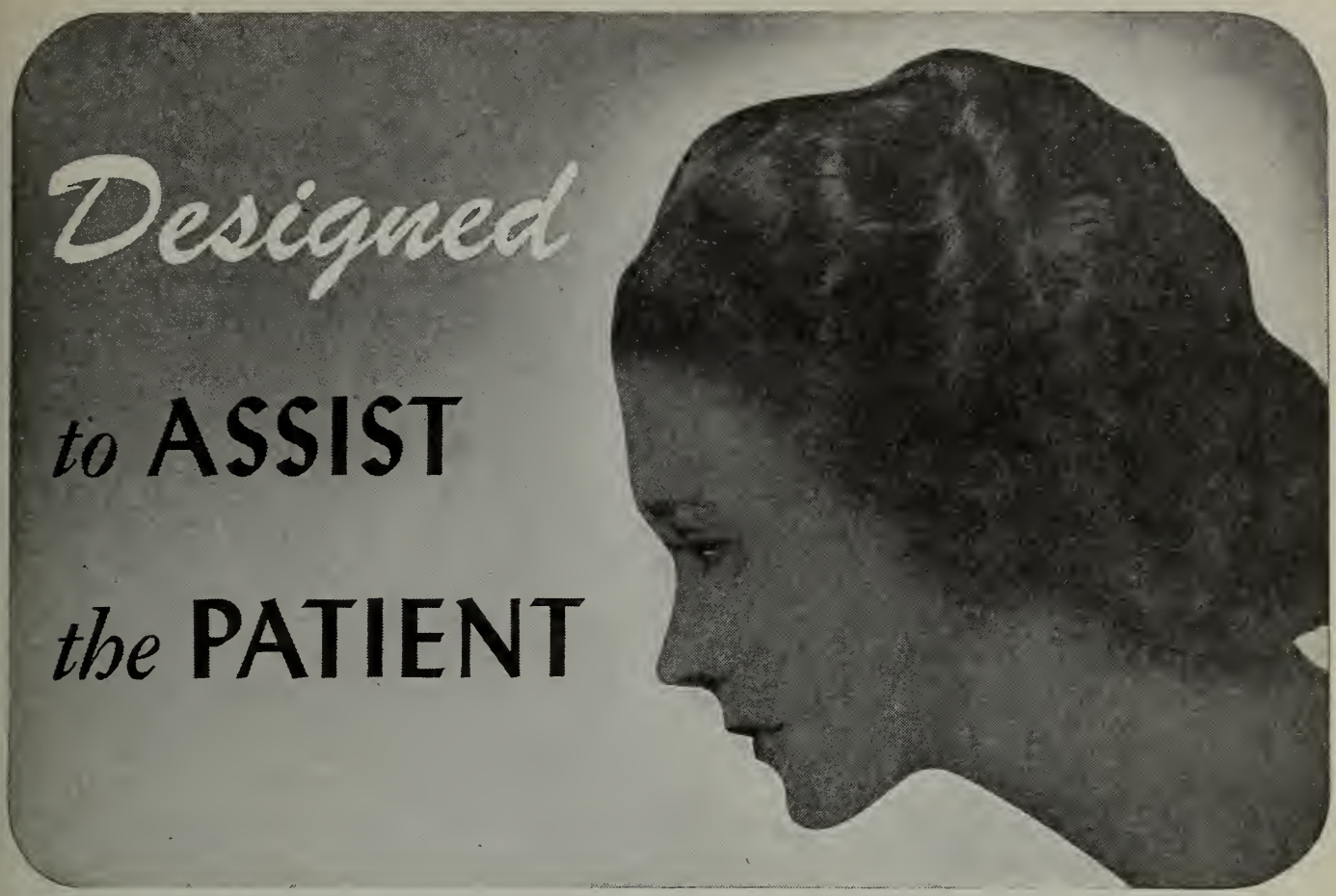
Barney J. Hein, M.D., Toledo,
Chairman.

Committee On War Participation

Since the activities of the Committee on War Participation, which has served also as the Ohio Procurement and Assignment Committee for Physicians, have been reported in detail each month in *The Ohio State Medical Journal*, there is little, if anything, new for the committee to report to the membership of the State Association at this time.

The committee is deeply appreciative of the cooperation and assistance it has received from local committees on war participation, members of the profession generally, officials of hospitals and medical schools, and others to whom it has gone for information and counsel.

Although almost 3,000 Ohio physicians have left civilian practice for military duty, no serious situations have arisen in Ohio so far as providing the civilian population with necessary medical attention. Ohio's medical profession can be proud of its war record both on the military and on the home front. Your committee has followed its original purpose of endeavoring to make a balanced distribution of Ohio's medical manpower



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between the military and the civilian population. The record indicates that it has been reasonably successful.

MUST NOT BE COMPLACENT

Lest we be lulled into unfounded complacency with respect to existing conditions, however, we should realize that the war is not over. Hard fighting and many casualties may be anticipated. Replacements in the medical corps of the Army and Navy will be required. This means that the demands of the Army and the Navy for additional medical officers will continue—a demand for younger medical officers especially.

The net result will be that hospitals, medical schools, institutions, and industry, will have to continue to get along with curtailed staffs. Civilians will have to continue to take their medical service on a rationed basis. Many, if not all, physicians of military age who can meet the physical standards and who have been retained in civilian practice because of local conditions, may have to be cleared as available for active duty as replacements for disabled medical officers. Some of them can be replaced in civilian practice by those separated from the services or by those completing internships or residencies but who are not physically qualified for military duty; but there is good reason to anticipate that the home front will have to tighten its belt again before the finale.

The outlook is not pleasant but we might as well face the facts and be prepared to meet them. The only answer is a little harder work by all civilian practitioners, already overworked; elimination of luxury services; closer cooperation between the physician and his patients with respect to keeping his appointments, scheduling of calls, etc.; additional curtailment of activities designed for the education of the medical school graduate—desirable activities, to be sure, but dispensable under wartime conditions; and use of lay personnel wherever possible for administrative, clerical and routine activities.

Robert Conard, M.D., Wilmington,
Chairman.

Committee on Education

Provision of adequate facilities for graduate medical training has become an increasingly important question as the war enters its final stages. That many Ohio physicians now serving in the armed forces will desire postgraduate instruction as they are returned from the services is a foregone conclusion. Ohio must be prepared to meet its responsibility for seeing that opportunities and facilities await them as they leave the services.

It will be remembered that at the 1942 Annual Session of the American Medical Association in Atlantic City, Ohio's delegates presented a resolution on this subject. The resolution, which was adopted, instructed the Council on Medical Education and Hospitals of the A.M.A. to make plans for refresher courses for physicians returning from military service and requested the Board of Trustees to confer with proper officials of the United States Government as to the possibilities of furloughing medical officers with full pay and allowances for a stated period in event they desire to take graduate training.

CONFERENCE HELD MARCH 5

With this in mind and realizing the importance of the question, the Committee on Education of the Ohio State Medical Association has initiated plans which, the committee hopes, will accomplish the desired results in this state.

In order to make satisfactory arrangements for coordination of activities, the committee on March 5, 1944, conferred with representatives of Ohio's three medical schools and of the Ohio Hospital Association. A study of existing facilities is being made and later plans for expansion of such facilities, if necessary, will be considered. The committee expects to work closely with the Council on Medical Education and Hospitals of the A.M.A. and other national medical groups which are studying the question from the national level. Your committee is not prepared to report on definite plans at this time. This will be done at a later date through *The Journal.*

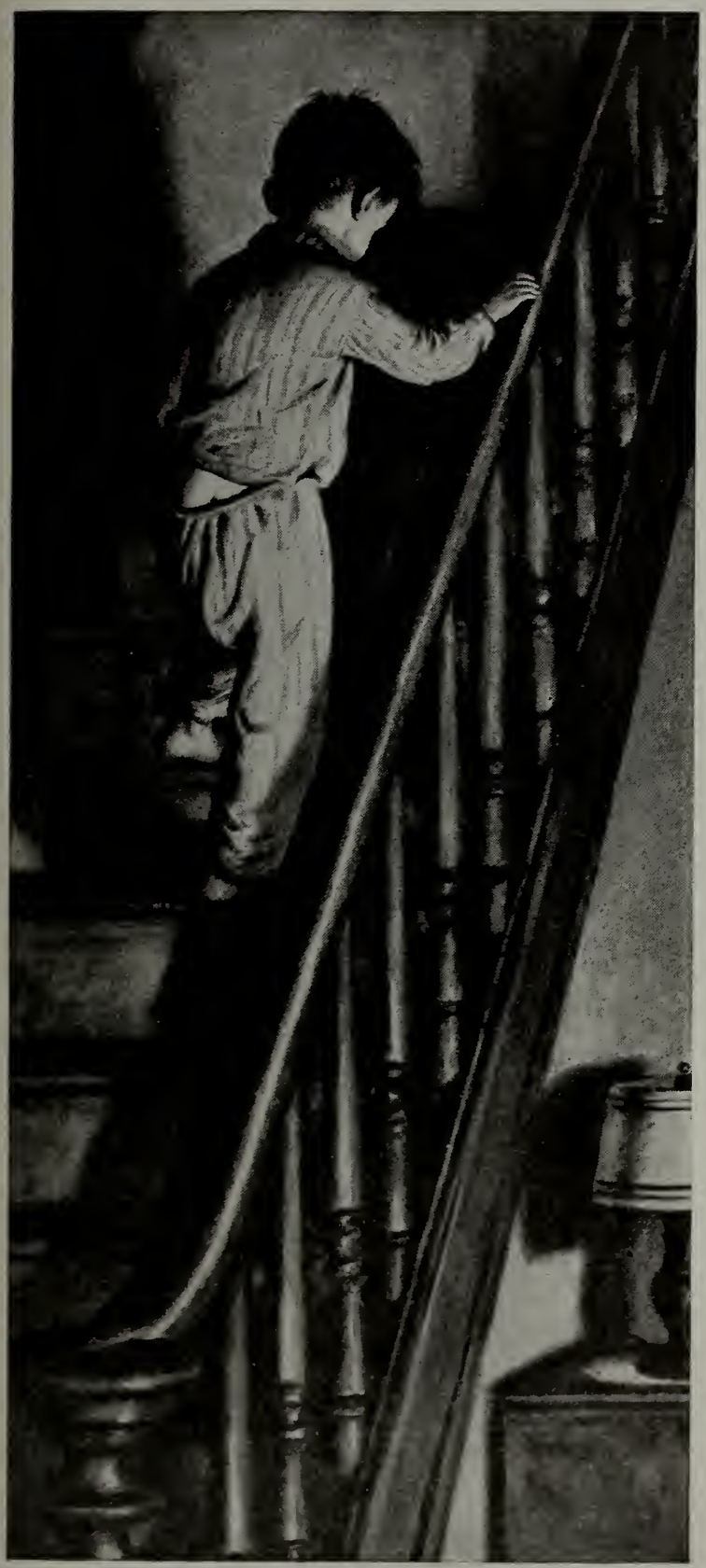
Obviously, medical organization, medical educators and hospital administrators all have a major role to play in this project and definite responsibilities to meet.

ROLE OF MEDICAL ORGANIZATION

The facilities of medical organization will have to be utilized to publicize the opportunities which Ohio will have to offer. It will be expected to carry on a program which will stimulate a desire on the part of the medical officer—the younger ones especially—to take advantage of the educational opportunities which will be provided. Also, it will be the function of medical organization to provide refresher courses, not only for former medical officers but also for physicians who have remained in civilian practice, as many of the latter group have been unable to leave their practices during the past several years for periods of refresher instruction as had been their custom prior to the war. It is the hope of your committee that the Ohio State Medical Association will be able to resume its regional postgraduate lectures at an early date as they will be of even greater importance during the postwar era.

It was suggested to The Council, after a meeting of the Committee on Education on March 5, that a three days' intensive clinical conference

Missing...



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Mom says you must be brave. "It's what your father would expect of us," she tells you when it's bedtime and your chin starts to feel shaky. Then she kisses you extra hard and turns her head away so you can't see her eyes.

You've never let her see you cry. Not once, since that telegram came and she twisted it all up in a ball, then smoothed it and put it in the desk.

But, lying in bed, you play "Pretend" — pretend you can hear his step as he comes up to your room — pretend you can feel a stubble brush your forehead. And sometimes, in the dark, you can almost smell a cigarette-y suit close to your face.

Later you dream — dreams that you don't tell about. And in the morning you wake up with that funny, empty feeling in your stomach.

★ ★ ★

Poor little guy. We — all of us — wish there were something we could do. Perhaps there is. Why shouldn't it be this?

We can resolve that the plans your father had for you shall remain within your reach, that you shall have the chance to grow and learn, that your opportunities will be bounded only by your own get-up-and-go, that you will progress and prosper in direct relation to your own ability — in a land of freedom and opportunity.

Those are the things your Dad valued, the things for which he gave his life. Though some may strive to change all that — provide you with the "benefits" of an all-powerful government, the "advantages" of regimentation, the "blessings" of bureaucracy — we can resolve they won't succeed.

★ ★ ★

You, son, won't read these words, and if you did, they wouldn't mean much to you now. But your father's friends — known and unknown — are making you a promise, just the same.

You may never hear it from their lips. But if you were older you would read it in their faces — recognize it in their spirit. They are determined to keep America free. To keep it a land in which government is the servant, not the master of the people. To keep it the kind of America your Dad wanted to preserve — for you.

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be held in Columbus in the Fall of 1944, designed primarily for physicians now in general practice. The Council, after giving the question thorough consideration, felt that such a meeting would not be feasible this year because of conditions resulting from the war. However, The Council heartily approved the idea that intensive clinical refresher courses should be offered to physicians in practice and instructed the Committee on Scientific Work to study the possibilities of arranging a project of this kind, to be used as the scientific program for the 1945 Annual Meeting of the State Association.

The Committee on Education, therefore, will confine its activities for the present to assembling necessary data regarding postgraduate educational facilities offered in Ohio, to preparing plans for expansion of such facilities if deemed necessary and to coordination and organization of the activities of the medical schools, hospitals and the State Association in this important field.

ROLE OF EDUCATORS AND HOSPITALS

Medical educators will be expected to complete plans for the expansion of the facilities of medical schools so they will be prepared to provide advanced training in preclinical fields and in the various specialties. Hospital administrators will be confronted with the responsibility of providing a greater number of residencies as the hospital training of many physicians now in the armed forces did not extend beyond internship.

The responsibility is larger than merely providing returning medical officers with additional training. The health of the people is at stake. It will suffer unless many physicians are given an opportunity to acquire knowledge and skill which they were prevented from receiving under wartime curtailment of medical education and as a result of service with the armed forces.

COOPERATION APPRECIATED

We appreciate the fine spirit of cooperation of the deans of Ohio's medical schools and of representatives of the Ohio Hospital Association and we are confident that with their continued help we will be able to improve the standing of Ohio with respect to the quality of graduate medical education and to provide ample facilities and opportunities for returning medical officers, as well as those in practice.

Sterling H. Ashmun, M.D., Dayton,
Chairman.

Committee on Industrial Health

One of the most important of all State Association projects during the past year has been the formation of an Industrial Health Program for Ohio. The responsibility for heading up this activity was assigned to the Committee on Industrial Health. The task of arousing the medical profession in Ohio to its responsibilities in providing professional leadership in the field of industrial health at a time when industrial employment has been at an all-time peak and when medical manpower on the home front has been reduced one-third has not been easy but satisfactory progress can be reported by the committee.

The committee felt that the first step was to stimulate interest locally by asking for the formation of a Committee on Industrial Health in each county medical society. Nearly all societies in industrial areas now have such a committee.

FLEXIBLE PLAN SUGGESTED

Obviously, a plan of action for such committees was necessary. Since the extent of industrial activity varies in different localities, it was necessary to produce a flexible plan in order to make it practical. The plan, in the form of an outline entitled "Fundamentals in the Organization and Operation of an Industrial Health Program by a County Medical Society", was prepared in October, 1943, printed in the *Ohio State Medical Journal* and distributed to the members of all local committees on industrial health. Described in the *Industrial Bulletin* of the Council on Industrial Health of the American Medical Association as "a monumental piece of work" and favorably commented upon by other medical publications, requests for reprints of the outline were received from many states.

The outline contains a brief foreward, followed by chapters on: objectives of the program; relationship between industrial medical service and the Workmen's Compensation Act; services which may be rendered by the full-time physician in industry and the part-time physician; communicable diseases and the industrial physician; legal responsibilities and limitations of nurses and lay personnel; and the education of physicians in industrial health and medicine.

Having produced a plan of action, the Committee was confronted with the problem of putting it to practical use. The pamphlet itself read well and was favorably received. It had promise of being included in the bibliography of future publications in the field of industrial health. However, literary merit was not the committee's objective. From the outset it had aspired to the awakening of the profession in Ohio to the need for medical leadership in meeting the health problems of industry, not only as another contribution of physicians to the war effort, but as a sound basis on which to plan for the health problems of the worker in normal times.

CONFERENCES HELD

To focus further attention on its program and objectives, the committee, with the cooperation

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FOR A FULL WEEK, the leading pharmacies of the United States will concentrate their energies on promoting a child health program.

They will have special educational displays—they will talk to parents—they will encourage them to visit physicians for regular child health examinations and immunizations against the common diseases. All this effort will be directed toward stimulating parents to more active cooperation in child health measures.

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of the Ohio Department of Health, arranged a series of conferences and programs, following the general theme: "Industrial Health and the Doctor". Similar meetings, to which all members of the State Association received invitations, were held at Toledo, Feb. 7; Cleveland, Feb. 8; Columbus, Feb. 9 and Cincinnati, Feb. 10, with afternoon and evening sessions.

Appearing on the program at each meeting were three out-of-state guest speakers of outstanding national reputation in the field of industrial medicine and industrial health: Dr. Carey P. McCord, Detroit, medical director, Industrial Health Conservancy Laboratories, Detroit; Dr. Frank F. Tallman, director of mental hygiene, Michigan State Hospital Commission, Detroit; and Dr. Rutherford T. Johnstone, director, Department of Occupational Diseases, Golden State Hospital, Los Angeles. Their topics were, respectively, "Conservation of Industrial Manpower", "Absenteeism and the Doctor", and "Occupational Disease Problems and How to Meet Them". Dr. Robert M. Andre, supervisor of the Medical Section, State Industrial Commission, spoke on "Relationship Between the Medical Profession and the Ohio Industrial Commission"; and Dr. Christopher Leggo, chief of the Division of Industrial Hygiene, Ohio Department of Health, led a general discussion at each meeting. In addition, brief talks were made by local physicians on the subjects: "Why a Local Industrial Health Program", "Planned Activity by the Local Committee on Industrial Health", and "The Place of the Individual Physician in Industrial Health".

Approximately 400 physicians attended the four meetings, and the addresses were favorably received. At all of the meetings, particularly in Cincinnati, a considerable number of industrial health nurses and personnel advisors also attended. The addresses of the guest speakers will appear in an early issue of *The Ohio State Medical Journal.* They are "must" reading for every Ohio physician interested in industrial health—in other words, every Ohio physician.

LOCAL ACTION NEEDED

It is the hope of the Committee on Industrial Health that the momentum gained by these meetings will not be lost; that the local committees will be inspired to sponsor programs on industrial medicine in the various county medical societies; and in general to encourage their colleagues to better prepare themselves to render proper medical service to their patients in industry. In order to make the program really effective, constructive relationships must be established with representatives of labor and industry and the nursing profession. It is suggested that every county medical society sponsor a meeting for laymen interested in industrial health, with the specific purpose of better acquainting them with the viewpoint of the medical profession in meeting the problems in that field.

As in every project that is worthwhile, much work needs to be done. In some counties, leaders of the profession, cognizant of the significance of this field of medical practice, have local programs under way, but in some, where there is enough industrial activity to warrant a need for an adequate industrial health program, the committee's pamphlet has apparently just been filed for future reference. Members of the Committee on Industrial Health and The Council of the Ohio State Medical Association are ready to assist any county medical society in the formation of an industrial health program.

FEE SCHEDULE BEING REVIEWED

Another important activity of the committee has been the initiation of a study of the medical rules and regulations and the General and Special Fee Schedules of the State Industrial Commission and preparation of suggested modifications. While there have been some changes in the fee schedule and additions to it since its establishment in 1926, it is generally agreed that in a number of instances the schedules need to be revised in order to bring them in line with present-day conditions. The committee also feels that there would be fewer misunderstandings if all important rules and regulations pertaining to the adjudication of fee bills were included in the printed booklet published by the Industrial Commission. Representatives of the Commission have been invited to assist the committee in its consideration of these questions.

Because of the extent of this job, a Sub-Committee on Workmen's Compensation was appointed by President Sherburne to undertake the study and report back to the Committee on Industrial Health. Members of the sub-committee are: Dr. Barney J. Hein, Toledo, chairman; Dr. C. W. Dawson and Dr. L. N. Jentgen, Columbus; Dr. J. Craig Bowman, Upper Sandusky; Dr. D. W. Heusinkveld and Dr. E. R. Bader, Cincinnati; Dr. James R. Driver, Dr. B. B. Sankey and Dr. M. Paul Motto, Cleveland; and Dr. John M. Van Dyke, Canton.

As stated in the February issue of *The Ohio State Medical Journal,* the committee solicits ideas and constructive suggestions from all members of the Ohio State Medical Association. They should be submitted in writing, in care of the State Headquarters Office of the Association, Columbus.

While the State Industrial Commission will have the final decision on any recommendations made by the committee, it is believed that the Commission will be amenable to suggestions which are fair and reasonable, and which will facilitate the administration of the Workmen's Compensation Act.

The sub-committee has made a good start and

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has assembled some basic data but is not prepared to make its final report at this time. When completed, the report will be submitted to The Council for review and approval and will then be transmitted to the Commission for its consideration.

Barney J. Hein, M.D., Toledo,
Chairman.

Red Cross Establishes Program To Train Persons in Home Nursing

The American Red Cross Nursing Service has established a plan to train 3,000,000 persons in home nursing as a means of easing the nurse and doctor shortage. According to the Red Cross, holders of Red Cross Home Nursing certificates are able to shorten the time of the doctor's visit by describing symptoms of the patient's illness, taking the patient's temperature, and having that information ready for the doctor. In addition they are equipped to follow his instructions for simple nursing care.

This nursing program has as service objectives:

1. To develop an appreciation of mental and physical health and a desire to build those habits that will safeguard them.
2. To teach the fundamental relationship between individual health and cleanliness, sanitation and arrangement of homes.
3. To build a basic understanding of the principles of prevention and control of disease.
4. To teach efficient methods of meeting the normal problems of the home—such as care of the baby, preschool child, school child, and the aged.
5. To develop some practical knowledge in the care of the sick under home conditions and according to the physician's directions.
6. To develop an intelligent understanding and an attitude of interest and cooperation in the solving of community health and problems.

The Red Cross course for adults may be given in a minimum period of 24 hours and is taught by a graduate registered nurse who has been authorized by Red Cross to teach the course. The textbook, "Red Cross Home Nursing", is used as the basic reference. The book is written in popular style and is simple, interesting and practical.

New OCD Medical Chief

The U.S. Office of Civilian Defense announces that Dr. W. Palmer Dearing, Senior Surgeon, U.S. Public Health Service, has been appointed Chief Medical Officer, to succeed Dr. George Baehr, who has served as Chief Medical Officer since June 1, 1941. Dr. Dearing has been Assistant Chief Medical Officer of the Office of Civilian Defense since July 8, 1941, and has assisted in the planning and development of the entire emergency medical program.

Going To A.M.A. Session? If So, Better Get Hotel Room Now

Physicians who are planning to attend the 94th Annual Session of the American Medical Association at Chicago, June 12-16 should apply for hotel reservations at once. A schedule of hotel rates and a blank for requesting accommodations appeared on page 56 of the Advertising Section of the March 11 issue of *The J.A.M.A.* Railroad reservations can be made 30 days in advance. It is recommended that reservations for Pullman accommodations for both the going and return trips be made as early as possible.

Youngstown Postgraduate Day, April 19

The usual fine program has been arranged for the Sixteenth Postgraduate Day of the Mahoning County Medical Society, Wednesday, April 19, at the Hotel Pick-Ohio, Youngstown. Speakers will include Dr. Ross Veal and Dr. E. R. Whitmore of the faculty of the Georgetown University Medical School, and Dr. W. D. Collier and Dr. E. C. Baker, Youngstown. All Ohio physicians are cordially invited to attend. The program follows:

Afternoon Session

2:30 "Clinical Problems Concerned with Blood Incompatabilities", Dr. Collier.
3:30 "Surgery of the Thrombosis of the Peripheral Veins", Dr. Veal.
4:30 "Venography of the Lower Extremity", Dr. Baker.

Dinner—6:00 P.M.

7:30 "Post-War Problems of Tropical Diseases in Civilian Practice", Dr. Whitmore.
8:30 "Acute Obstruction of the Small Intestines", Dr. Veal.

Coming Meetings

Ohio State Medical Association, Columbus, May 2-4.

American Medical Association, Chicago, June 12-16.

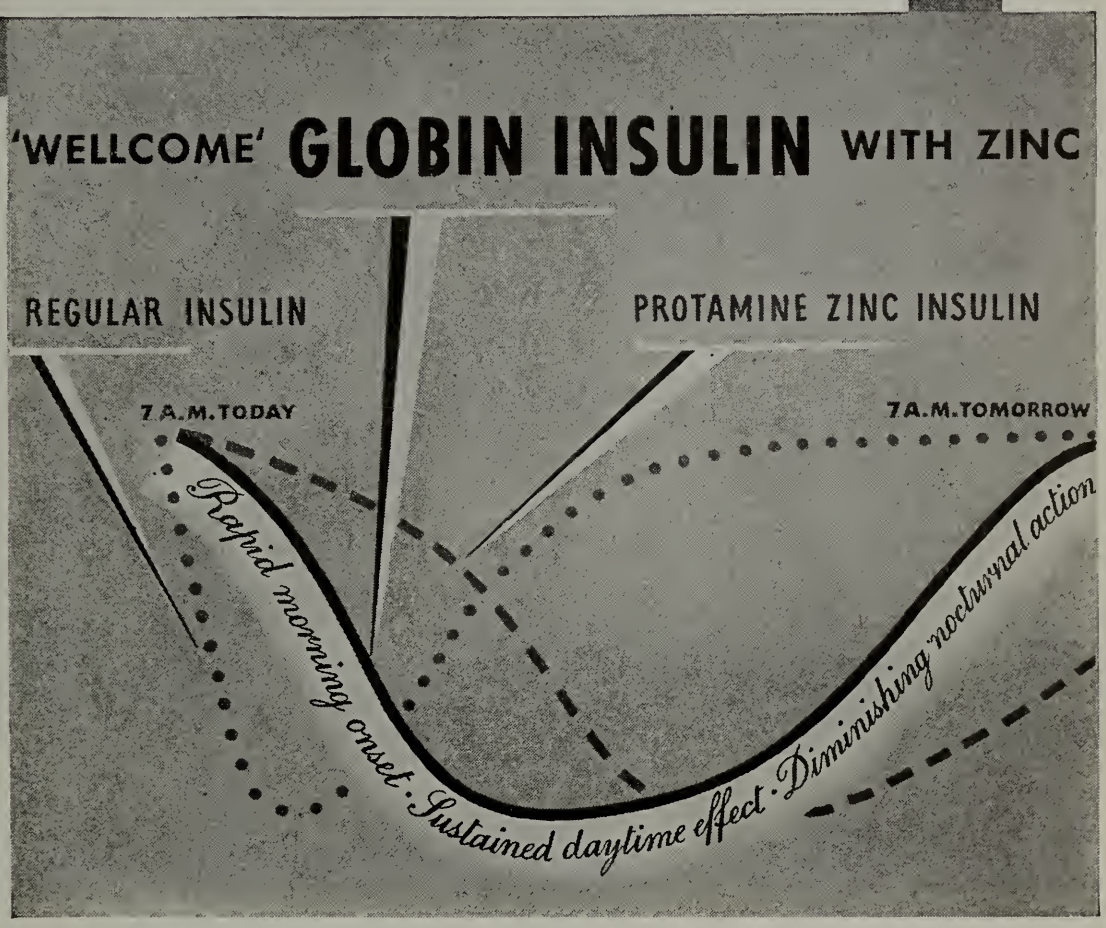
Northern Tri-State Medical Association, Toledo, April 11.

Mahoning County Postgraduate Day, Youngstown, April 19.

American Association for Thoracic Surgery, Chicago, May 5-6.

Governor Bricker has reappointed Dr. Thomas H. George, Cleveland as a member of the State Medical Board for a term ending March 18, 1951.

Control...*the keynote in insulin action*



A schematic representation of the effects of various insulins on the blood sugar of a fasting diabetic patient.

• 'Wellcome' Globin Insulin with Zinc, a new type of insulin, offers an advance in diabetic control. It provides a rapid onset of action; strong prolonged effect during the day when most needed; and diminishing action at night. Nocturnal insulin reactions are rarely encountered.

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ACCEPTED AMERICAN MEDICAL ASSN

ANNUAL AUDIT OF BOOKS OF THE OHIO STATE MEDICAL ASSOCIATION AND THE OHIO STATE MEDICAL JOURNAL FOR YEAR ENDED DECEMBER 31, 1943, BY KELLER, KIRSCHNER, MARTIN AND CLINGER, CERTIFIED PUBLIC ACCOUNTANTS, COLUMBUS, OHIO

OHIO STATE MEDICAL ASSOCIATION

Statement of Cash Receipts and Disbursements—Treasurer's Account for the year ended December 31, 1943

CASH AND BONDS ON HAND JANUARY 1, 1943		
Cash		$ 701.91
United States Treasury Bonds		80,000.00
Total on hand, January, 1943		$ 80,701.91
RECEIPTS		
Transfers from Executive Secretary's account:		
Membership dues, 1943	$35,485.00	
Membership dues prior years	42.00	
Total dues transferred	$35,527.00	
Interest on U. S. Treasury Bonds	1,823.17	
Miscellaneous receipts from Ohio State Medical Journal	94.47	
Refund of telephone and telegraph from 1942	20.70	
Total receipts		$ 37,465.34
TOTAL TO BE ACCOUNTED FOR		$118,167.25
DISBURSEMENTS		
Ohio State Medical Journal		$ 10,000.00
Executive Secretary's salary		6,300.00
Executive Secretary's expense		664.96
Asst. Executive Secretary's salary		4,800.00
Asst. Executive Secretary's expense		527.12
President's expense		193.84
Treasurer's salary		300.00
Council's expense		856.25
Annual meeting expense		1,000.00
Bureau of Public Relations:		
Director's salary	$ 750.00	
Committee expense	1,500.00	
Director's expense	8.85	
Operating expense	2,333.00	4,591.85
American Medical Assn. delegates		170.12
Postage, telephone and telegraph		1,979.93
Rent		2,040.00
Stenographic salaries		3,210.00
Stationery, printing and supplies		544.06
Miscellaneous Committee expense		124.84
Auditing		115.00
Dues and subscriptions		36.65
Employees' bonds		28.80
Liability insurance		40.00
Industrial insurance		10.23
Unemployment insurance		119.01
War participation committee expense		683.67
Miscellaneous expense		142.23
Victory tax paid for Ohio State Medical Journal (see receipts)		94.47
Refund of dues—military service		539.00
Total disbursements		$ 39,112.03
CASH ON DEPOSIT AND BONDS ON HAND AT DECEMBER 31, 1943		
The Huntington National Bank—Treasurer's account		$ 8,055.22
United States Treasury Bonds:		
Series G—12 year 2½%	$40,000.00	
Issue of 1948-50 2%	25,000.00	
Issue of 1955-60 2⅞%	5,000.00	
Issue of 1959-60 2¾%	1,000.00	71,000.00
Total cash and bonds on hand December 31, 1943		$ 79,055.22
Total Accounted for		$118,167.25

OHIO STATE MEDICAL JOURNAL

The financial condition of the Ohio State Medical Journal at December 31, 1943 was:

ASSETS

Current Assets		
Cash—The Ohio National Bank	$ 3,126.57	
Cash—Petty	10.00	
Total cash		$ 3,136.57
Accounts receivable		794.14
Total current assets		$ 3,930.71
Current liabilities		150.00
Net current assets		$ 3,780.71
Property Assets		
Furniture and fixtures (depreciated value)		2,330.34
Total Net Assets		
(Represented by surplus)		$ 6,111.05

LIABILITIES AND SURPLUS

Current Liabilities		
Subscriptions prepaid		$ 150.00
Surplus		
Surplus at December 31, 1942	$ 5,607.14	
Add surplus for the year ended December 31, 1943	503.91	
Surplus at December 31, 1943		6,111.05
Total Liabilities and Surplus		$ 6,261.05

STATEMENT OF PROFIT AND LOSS

Revenue		
Advertising		$ 14,402.14
Less:		
Commissions on advertising	$ 882.91	
Cash discounts	272.55	
Total deductions		1,155.46
Advertising revenue—net		$ 13,246.68
Circulation		10,342.35
Total revenue		$ 23,589.03
Expenses		
Journal printing	$15,150.33	
Office salaries	5,695.00	
Journal postage	716.46	
Journal illustrations and engraving	119.06	
Journal envelopes	685.19	
Depreciation	255.86	
Clipping service	102.50	
Dues and subscriptions	46.40	
Office supplies and expense	314.32	
Total expenses		23,085.12
Net profit transferred to surplus		$ 503.91



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Proceedings of The Council

Extended and Important Meeting Held in Columbus on March 12 When Vital Economic and Legislative Questions Were Discussed

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the State Headquarters Office, Columbus, on Sunday, March 12, 1944. The following were present: President Sherburne, President-Elect Schriver, Treasurer LeFever; Councilors Swartz, Messenger, Noble, Brindley, Rutledge, Lincke, Swan, Micklethwaite, and Knoble; Dr. Forman, Editor of *The Journal;* Executive Secretary Nelson and Assistant Executive Secretary Saville.

On **motion** by Dr. Brindley, seconded by Dr. Lincke, and **carried**, the minutes of the last meeting of The Council held on December 12, 1943, were **approved.**

Membership statistics were reported as follows: Total membership as of March 11, 1944—6,129, of which 1,776 were military members; compared to a total membership of 6,783 on December 31, 1943, of which 1,772 were military members.

Members of The Council reported on activities in and visits to their respective county societies.

APPOINTMENTS CONFIRMED

At the request of President Sherburne, The Council considered his appointments to the Special Sub-Committee on Workmen's Compensation of the Committee on Industrial Health, and on **motion** by Dr. Knoble, seconded by Dr. Micklethwaite, and **carried**, The Council approved the following appointments: Dr. Barney J. Hein, Toledo, chairman; Dr. C. W. Dawson and Dr. L. N. Jentgen, Columbus; Dr. J. Craig Bowman, Upper Sandusky; Dr. D. W. Heusinkveld and Dr. E. R. Bader, Cincinnati; Dr. B. B. Sankey, Dr. James R. Driver, Dr. M. Paul Motto, Cleveland; and Dr. John M. Van Dyke, Canton.

The Executive Secretary, on behalf of the Committee on Scientific Work, reported on the final plans and arrangements for the 1944 Annual Meeting, May 2, 3, 4, Neil House, Columbus. Proofs of the program were distributed to members of The Council.

STAFF REORGANIZATION APPROVED

A report from the Committee on Auditing and Appropriations, which had met on Saturday, March 11, was presented by Dr. Schriver in the absence of Dr. McNamee, chairman of the committee. On **motion** by Dr. Schriver, seconded by Dr. Swartz, and **carried**, the committee's recommendations regarding the readjustment of stenographic and clerical work in the State Headquarters Office, necessitated through the resignation of Miss Alice Haney, and salary readjustments were approved.

As recommended by the Committee on Auditing and Appropriations and by The Council, the Executive Secretary was authorized to employ additional stenographic or clerical help when and if competent personnel is obtainable.

An additional recommendation of the committee, approved by The Council, authorized the Executive Secretary to arrange for fire insurance on office furniture and equipment.

Copies of the audit made by Keller, Kirschner, Martin and Clinger, Columbus, certified public accountants, of the books of the Ohio State Medical Association and of *The Ohio State Medical Journal* for the calendar year 1943, were **presented** to The Council for consideration. On **motion** by Dr. Lincke, seconded by Dr. Rutledge, and **carried**, the audit was approved and ordered submitted to the House of Delegates at the 1944 Annual Meeting.

WAGNER BILL PAMPHLETS

Mr. Saville, Assistant Executive Secretary, reported on the distribution of the pamphlets in opposition to the Wagner Bill. He reported that to date 350,000 copies of the pamphlet had been printed and 319,000 copies distributed to physicians, county medical societies, members of the Woman's Auxiliary, various state associations and organizations, industrial firms, hospital service groups and others. Mr. Saville also reported that approximately 250 copies of the model talk on the Wagner Bill had been distributed and that additional copies were being printed for distribution.

There was a discussion of the address made by Governor John W. Bricker at Peoria, Illinois, on February 22. On **motion** by Dr. Swartz, seconded by Dr. Knoble, and **carried**, comment on the Governor's address in *The Ohio State Medical Journal* was authorized.

WASHINGTON OFFICE

Reference was made to an article published in the February 26, 1944, issue of *The Journal of the American Medical Association* to the effect that the Board of Trustees had authorized "the necessary preliminary steps" for establishment in Washington, under the auspices of the Council on Medical Service and Public Relations, of an office of medical economic research. Members of The Council expressed the hope that the opening of this office in the near future would be an answer to the recommendations made to the

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House of Delegates of the A.M.A. in June, 1943, by the Ohio delegation and others.

NEW ORGANIZATIONS DISCUSSED

Communications regarding the National Physicians' Committee, the Association of American Physicians and Surgeons of Lake County, Indiana, the United Public Health League (formerly Western States Public Health League) and the "declaration of medical policies" and pledge adopted by the House of Delegates of the Michigan State Medical Society were considered in detail and, on **motion** by Dr. Messenger, seconded by Dr. Micklethwaite, and **carried**, were ordered filed for future reference.

A communication from Dr. H. H. Skinner, Yakima, Washington, chairman of the Maternal and Child Welfare Committee, Washington State Medical Society, with respect to activities to bring about corrections and improvements in the Children's Bureau Maternal and Child Health Program was given thorough consideration. On **motion** by Dr. Schriver, seconded by Dr. Lincke, and **carried**, this communication was referred to the Committee on Public Relations and Economics for study as to the possibilities of initiating similar activities in Ohio.

B.U.C. STUDY CONSIDERED

Consideration was given to studies which are being made by the Advisory Council of the Ohio Bureau of Unemployment Compensation with respect to sickness disability insurance. On **motion** by Dr. Knoble, seconded by Dr. Swartz, and **carried**, this question was referred to the Committee on Public Relations and Economics for review and recommendations.

There was a general discussion of the studies being made by the administrators of Blue Cross Hospital Service Plans with respect to medical reimbursement insurance.

Reference was made to the action of the House of Delegates of the American Bar Association on February 28, 1944, and the adoption of a report condemning the Wagner-Murray-Dingell Bill, which report was published in full in the March 11 issue of *The Journal of the A.M.A.*

REPORT BY DR. MUNDY

A communication from Dr. Carll S. Mundy, Toledo, representative of the Ohio State Medical Association on the Sub-Committee on Health of the Ohio Land-Use Planning Committee, was read and discussed. In adopting a **motion** made by Dr. Schriver and seconded by Dr. Brindley, The Council expressed appreciation to Dr. Mundy for his excellent report and suggestions, and ordered the communication submitted to the Committee on Public Relations and Economics for its information and guidance.

The amendment adopted by the Butler County Medical Society to its constitution and by-laws to provide for a council to consist of the president, president-elect, secretary-treasurer, the past-president, and the delegate or alternate-delegate to the House of Delegates to the Ohio State Medical Association, was approved on **motion** by Dr. Brindley, seconded by Dr. Noble, and **carried.**

A communication from a Cleveland physician, asking The Council to intercede on his behalf with respect to his application for membership in the Cleveland Academy of Medicine which had been rejected by the Academy, was discussed and the Executive Secretary, on **motion** by Dr. Micklethwaite, seconded by Dr. Lincke, and **carried,** was instructed to inform the physician that under the Constitution and By-Laws of the Ohio State Medical Association the question of eligibility to membership rests entirely with the medical society of the county of residence and that The Council had no jurisdiction with respect to his case.

REHABILITATION PROGRAM

Dr. Edward Harlan Wilson, Columbus, appeared before The Council, on invitation of The Council, to explain and discuss the new rehabilitation law passed by the 78th Congress. Dr. Wilson was recently appointed a member of the advisory committee to the Ohio Bureau of Vocational Training. After Dr. Wilson's presentation and a general discussion, on **motion** by Dr. Schriver, seconded by Dr. Harding, and **carried**, The Council commended Dr. Wilson on his report and for having discussed the matter with The Council, and referred the question to the Committee on Public Relations and Economics for consideration and cooperation with Dr. Wilson on the activities of the advisory committee and any problems which may arise.

Mr. Saville reported on the Industrial Health Conferences held in February under the auspices of the Committee on Industrial Health and the Ohio Department of Health.

POSTWAR EDUCATION

A report was presented by the Executive Secretary on the meeting of the Committee on Education, held on Sunday, March 5, 1944, in the Columbus office for the purpose of discussing postwar medical education. That meeting had been attended, in addition to members of the committee, by representatives of the Ohio Hospital Association and representatives of Ohio's three medical colleges. The following recommendation of the committee was submitted to The Council for consideration: That the Ohio State Medical Association present a three days' intensive clinical conference, designed primarily for men in general practice, in Columbus in the Fall of 1944 for which a registration fee would be charged and honorariums offered for teaching participants. The Council gave this recommendation very thorough consideration, but there was

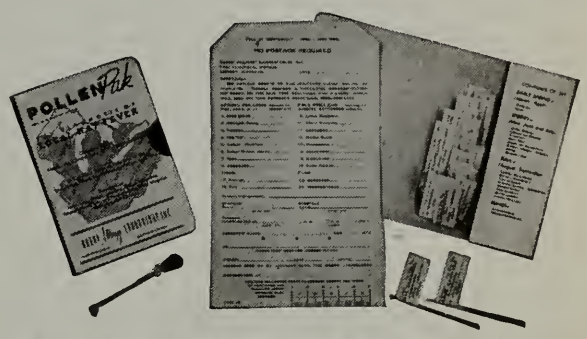
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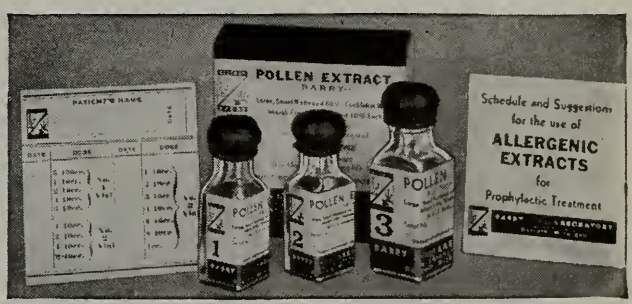
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a general feeling on the part of the members of Council that a meeting such as the one proposed, which would require extensive plans and arrangements, would not be feasible at the present time because of war conditions. On **motion** by Dr. Lincke, seconded by Dr. Swartz, and **carried**, the Executive Secretary was instructed to inform the committee of The Council's opinion and to commend the committee for the work which it is undertaking in assembling data on postwar education facilities in Ohio for returning medical officers. The motion also instructed the Executive Secretary to inform the Committee on Scientific Work that The Council would like to have that committee consider seriously the possibilities of arranging an intensive clinical conference, as recommended by the Committee on Education, as the scientific program for the 1945 Annual Meeting of the Ohio State Medical Association.

MISCELLANEOUS ACTIONS

The request from the Ohio Optometric Association that the Ohio State Medical Association cooperate on a legal matter had the approval of The Council on **motion** by Dr. Brindley, seconded by Dr. Knoble, and **carried.**

A communication from the Cleveland Academy of Medicine with respect to the recent action of The Council on the practice of medicine by hospitals was read and ordered filed, on **motion** by Dr. Noble, seconded by Dr. Harding, and **carried.**

Communications about the activities of an organization known as the National X-Rays Surveys Company were discussed. On **motion** by Dr. Micklethwaite, seconded by Dr. Rutledge, and **carried**, The Council instructed the Executive Secretary to ask the Secretary of the State Medical Board to investigate the activities of this company and to advise if the organization is or is not engaged in the practice of medicine.

The Council considered a suggestion that an informal conference be held in the Columbus office on April 23 to be attended by official representatives of county medical societies which are considering the possibilities of organizing a medical service plan. On **motion** by Dr. LeFever, seconded by Dr. Micklethwaite, and **carried**, the Executive Secretary was instructed to communicate with county societies having plans under consideration, or interested in drafting medical service plans, to invite such societies to send representatives to a conference of this kind.

A request from the State Executive Committee of the Women's Field Army of the American Society for the Control of Cancer, asking The Council to approve the appointment of Dr. Max Zinninger, Cincinnati, to the executive committee, was read. On **motion** by Dr. Schriver, seconded by Dr. Brindley and **carried**, the appointment of Dr. Zinninger to the executive committee of the Women's Field Army was approved.

On **motion** by Dr. Schriver, seconded by Dr. Micklethwaite, and **carried**, The Council, by a standing vote, expressed sincere regret at the recent death of Dr. I. P. Seiler, who for 20 years had been a member of The Council prior to his retirement from that office in 1942, and instructed the Executive Secretary to convey to Mrs. Seiler and Dr. Seiler's son condolence and sympathy.

There being no further business, The Council adjourned until Tuesday afternoon, May 2, during the 1944 Annual Meeting.

Attest: CHARLES S. NELSON,
Executive Secretary.

New Income Tax Law and How It Will Affect Physicians

Under the provisions of the Revenue Act of 1943, which became a law over the President's veto, Ohio physicians, along with other taxpayers, will be required to file an estimate of their income and victory tax on 1944 income, on or before April 15. At the same time, one-fourth of the estimated tax will be due and payable, and the balance in quarterly payments by June 15, September 15 and December 15.

The actual income tax return for 1944 will be due on or before March 15, 1945, at which time the taxpayer will have to pay the difference between the total amount paid based on his estimated return and the actual tax computed.

Blanks to be used in filing the estimated tax for 1944 will be mailed by the District Collectors of Internal Revenue to all taxpayers who filed estimated declarations for 1943.

Income taxes of individuals for 1944 will be somewhat higher than in 1943 because of certain changes in the law. The credit of 10 per cent for earned income has been abolished. The victory tax has been modified so that it is now a flat three per cent of the victory tax net income in excess of $624 regardless of family status. Excise taxes, such as those on theater tickets, stamp taxes, use taxes on automobiles and boats, taxes on club dues, telephone calls, etc., are no longer deductible, unless they fall in the category of business expense.

Except for the changes noted above, items which may be deducted by a physician from his gross income remain the same as explained in "Suggestions for Physicians Relative to U.S. Income Tax Law Deductions, Procedures, Forms and Payments", pages 153-156, February, 1944, issue, *The Ohio State Medical Journal.*

East Liverpool—Dr. John Fraser discussed the Wagner Bill at a meeting of the Lions Club.

Piqua—Dr. George A. Woodhouse, Pleasant Hill, explained the implications of the Wagner Bill at a meeting of the Rotary Club.

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So, if the C. O. assigns you to Baker's Modified Milk, Butch, you can take it easy--you're scheduled to come out all right!

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Military Roster Now Totals 2,775; Names of Those Added During Past Month Listed; Many Are Promoted

MILITARY roster of the Ohio State Medical Association totaled 2,775 on March 20 when this issue of *The Journal* went to press. The names of 31 Ohio physicians were added during the past month. Those on the roster included 2,362 Army medical officers; 344 Navy medical officers and 69 holding full-time appointments with governmental agencies directly connected with the war effort. Those whose names have been added to the roster, those promoted and the tabulation by counties, follow:

NAMES ADDED TO MILITARY ROSTER

Name	City	Rank
Angerman, R. H.	Massillon	Lt. (j.g.), U.S.N.
Beall, Neil P., Jr.	Cleveland	Lt. (j.g.), U.S.N.
Bennett, A. E.	Cleveland	Lt. Comdr., U.S.N.
Brody, David R.	Youngstown	1st Lt., U.S.A.
Fitzgerald, Geo. P., Jr.	Springfield	1st Lt., U.S.A.
Flachs, Kamillo	Cincinnati	1st Lt., U.S.A.
Godwin, Bernard E.	Toledo	1st Lt., U.S.A.
Goldberg, Maurice S.	Dayton	1st Lt., U.S.A.
Gruen, Franz	Elyria	1st Lt., U.S.A.
Horrocks, Jack B.	Cleveland	1st Lt., U.S.A.
Kretchmer, Henry	Cleveland	Lt. (j.g.), U.S.N.
Krisko, Michael J.	Cleveland	1st Lt., U.S.A.
Landt, Harry Edw.	Cincinnati	Capt., U.S.A.
Marcus, Louis J.	Cleveland	Capt., U.S.A.
McCormick, Rufus P.	Cleveland	1st Lt., U.S.A.
Miller, James D.	Youngstown	1st Lt., U.S.A.
Moon, Richard P.	Dayton	1st Lt., U.S.A.
Morrison, Wm. H.	Dayton	1st Lt., U.S.A.
Mumma, Charles E.	Dayton	1st Lt., U.S.A.
Neely, Richard C.	Cleveland	1st Lt., U.S.A.
Rampp, Richard E.	Cleveland	Lt. (j.g.), U.S.N.
Rayman, Jonas B.	Toledo	Capt., U.S.A.
Ross, Thomas F.	Columbus	Lt. Comdr., U.S.N.
Schmitt, Clarence F.	Canton	1st Lt., U.S.A.
Shaffer, James M.	Dayton	1st Lt., U.S.A.
Shilling, M. D.	Ashland	Lt., U.S.N.
Shuer, Bernard B.	Toledo	1st Lt., U.S.A.
Stoll, Richard G.	Cleveland	1st Lt., U.S.A.
Tetalman, Sam	Cleveland Heights	1st Lt., U.S.A.
Van Ordstrand, Howard S.	Cleveland Hgts.	1st Lt., U.S.A.
Ward, Vincent C.	Wooster	Capt., U.S.A.

WIN PROMOTIONS

Name	City	Rank
Angle, Robert G.	Mansfield	Capt., U.S.A.
Anzinger, F. Wm.	Springfield	Capt., U.S.A.
Ball, O. D.	New Lexington	Major, U.S.A.
Blackstone, Paul A.	Bellville	Major, U.S.A.
Booth, George T.	Toledo	Capt., U.S.A.
Braun, E. J.	Akron	Capt., U.S.A.
Breckenridge, R. A.	Cuyahoga Falls	Major, U.S.A.
Brown, L. Emmitt, Jr.	Akron	Lt. Col., U.S.A.
Campbell, R. D.	Mansfield	Capt., U.S.A.
Carlisle, Richard C.	Columbus	Major, U.S.A.
Chaikin, Wm. Earl	Cleveland	Capt., U.S.A.
Crawford, M. E.	Cleveland	Capt., U.S.A.
Cronin, John F.	Cincinnati	Major, U.S.A.
Curran, Thomas R.	Columbus	Capt., U.S.A.
Daus, Homer J.	Cleveland	Capt., U.S.A.
de Maine, P. B.	Akron	Capt., U.S.A.
Dowell, Lloyd L.	Navarre	Capt., U.S.A.
Eisner, David G.	Cleveland	Lt. Col., U.S.A.
Fancher, Paul S.	Delaware	Col., U.S.A.
Gallen, John J.	Columbus	Major, U.S.A.
Gettman, R. L.	Marion	Capt., U.S.A.
Geroch, Stephen V.	Akron	Capt., U.S.A.
Greenberg, Marcel	Cleveland	Major, U.S.A.
Gunn, H. M.	Ashland	Lt. Col., U.S.A.
Hapke, Fred B.	Troy	Capt., U.S.A.
Hargrave, Dudley W.	Cincinnati	Capt., U.S.A.
Haynie, Harold C.	Toledo	Capt., U.S.A.
Herbert, Joseph M.	Youngstown	Capt., U.S.A.
Higley, C. S.	Cleveland	Lt. Col., U.S.A.
Irish, E. A.	Barberton	Major, U.S.A.
Jacques, Richard H.	Columbus	Capt., U.S.A.
Karam, James J.	Canton	Capt., U.S.A.
Lecklitner, Myron D.	Wilmot	Capt., U.S.A.
Lerner, David L.	Cincinnati	Major, U.S.A.
Miles, R. Keith	Thompson	Capt., U.S.A.
Obetz, Robin C.	Columbus	Major, U.S.A.
Pumphrey, Gordon H.	Mt. Vernon	Lt. Col., U.S.A.
Reeves, James R.	Columbus	Major, U.S.A.
Rice, Milo B.	Pandora	Major, U.S.A.
Robben, Francis J.	Bridgeport	Lt. Col., U.S.A.
Rosenow, Oscar F.	Columbus	Capt., U.S.A.
Rothermich, Norman O.	Columbus	Capt., U.S.A.
Schroer, Wm. A.	Ft. Loramie	Capt., U.S.A.
Shapiro, Jacob	Delphos	Major, U.S.A.
Shensa, Lewis S.	Youngstown	Capt., U.S.A.
Steele, Wendell M.	Newark	Major, U.S.A.
Taylor, H. P.	Cleveland	Lt. Col., U.S.A.
Ternocky, Frank	Bloomville	Capt., U.S.A.
Van Buren, George	Akron	Capt., U.S.A.
Vanneter, James C.	Columbus	Major, U.S.A.
Venar, Yasha A.	Cleveland	Major, U.S.A.
Vinnedge, Wm. F.	Hamilton	Major, U.S.A.
Wales, Craig C.	Youngstown	Capt., U.S.A.
Wiedemer, Hall S.	Columbus	Capt., U.S.A.
Wills, Benjamin F.	McArthur	Major, U.S.A.
Wilson, Herman E.	Van Wert	Lt. Col., U.S.A.
Wood, Cyrus R.	Port Clinton	Major, U.S.A.
Yospur, David	Gallipolis	Capt., U.S.A.

TABULATION BY COUNTIES

Adams	2	Guernsey	6	Muskingum	9
Allen	38	Hamilton	418	Noble	1
Ashland	11	Hancock	12	Ottawa	9
Ashtabula	17	Hardin	7	Paulding	2
Athens	12	Harrison	4	Perry	4
Auglaize	6	Henry	2	Pickaway	5
Belmont	12	Highland	8	Pike	2
Brown	4	Hocking	4	Portage	2
Butler	29	Holmes	2	Preble	7
Carroll	1	Huron	15	Putnam	6
Champaign	8	Jackson	1	Richland	38
Clark	32	Jefferson	30	Ross	24
Clermont	9	Knox	11	Sandusky	11
Clinton	7	Lake	18	Scioto	19
Columbiana	11	Lawrence	6	Seneca	12
Coshocton	4	Licking	17	Shelby	8
Crawford	10	Logan	8	Stark	97
Cuyahoga	683	Lorain	38	Summit	147
Darke	6	Lucas	157	Trumbull	26
Defiance	4	Madison	6	Tuscarawas	19
Delaware	7	Mahoning	117	Union	2
Erie	10	Marion	16	Van Wert	9
Fairfield	9	Medina	13	Vinton	2
Fayette	2	Meigs	3	Warren	4
Franklin	224	Mercer	6	Washington	7
Fulton	6	Miami	13	Wayne	14
Gallia	4	Monroe	1	Williams	8
Geauga	4	Montgomery	140	Wood	17
Greene	7	Morgan	3	Wyandot	3
Total					2775

Industrial Surgeons To Hold War Conference in St. Louis, May 8-14

The Second "War Conference" of industrial physicians, industrial hygienists and industrial nurses will be held in St. Louis, Missouri, May 8-14, at the Hotel Jefferson. The participating organizations are American Association of Industrial Physicians and Surgeons, American Hygiene Association, National Conference of Governmental Hygienists, and American Association of Industrial Nurses.

Hotel reservations are being handled by John Reinhardt, Chairman, "War Conference" Housing Bureau, Syndicate Trust Bldg., St. Louis, Missouri.

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Ampuls Diethylstilbestrol in Oil (corn), 1-cc., for intramuscular injection: 0.2 mg.; 0.5 mg.; 1.0 mg. and 5.0 mg. in boxes of 6, 25, 50 and 100.

Pessaries (Vaginal Suppositories) 0.1 mg., and 0.5 mg., boxes of 12 and 50.

A preparation of natural estrogens, Amniotin is also available. It is obtained from urine of pregnant mares—is a highly concentrated, non-crystalline preparation of estrone together with small varying amounts of other estrogenic ketones. It is supplied in corn oil solution for intramuscular use and in capsules for oral administration. Also in pessaries.

Particularly economical is Amniotin in Oil, in 10-cc. vials—10,000 I.U. per cc., and 20,000 I.U. per cc.—and in 20-cc. vials containing 2000 I.U. per cc. These forms also permit utmost flexibility in adjusting dosage to meet the varying needs of patients.

For literature write the Professional Service Dept., 745 Fifth Ave., New York 22, N. Y.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WASHINGTON OFFICE TO BE OPENED BY A.M.A.

In its February 26, 1944, issue, *The Journal of the American Medical Association* published, on page 583, an article under the heading, "Council on Medical Service and Public Relations Proposes Washington Office for Medical Economic Research".

The article stated that the new Council suggested to the Board of Trustees of the A.M.A. on February 14-15 the establishment in Washington, under the auspices of the Council on Medical Service and Public Relations, of an office of medical economic research. The following is quoted from the article:

"This office would be charged with the collection of information and statistical data concerning medical care, its distribution, its availability, its costs and its control in various portions of the United States. The information thus collected will be made available to the medical profession through the publications of the American Medical Association, also to the Bureau of Medical Economics of the American Medical Association for its studies of this problem, and to other appropriate agencies interested in the extension of medical service, the provision of medical care and related subjects. The Board of Trustees has authorized the necessary preliminary steps for this project."

Stripped of verbiage, this means that the American Medical Association is going to establish an office in Washington, unless the Board of Trustees changes its mind which, we hope, will not happen. That office can be an asset or a liability, depending on how much or how little it does, what it does, how adequately it is financed and the kind of personnel that is selected to man it.

It is a real step in the right direction. The Council on Medical Service and Public Relations and the Board of Trustees of the A.M.A. deserve commendation for having taken this action.

It will be recalled that the Ohio State Medical Association has been on record as favoring the establishment of an A.M.A. office in Washington. Ohio's delegates made a last-ditch fight on this question in the House of Delegates of the A.M.A. at its 1943 session. Moreover, this *Journal* has expressed confidence on several occasions that the officials of the A.M.A. would be wise enough to realize the importance of this step and that a Washington office would be opened in the not too distant future. We have discouraged in editorial comments the formation of new and special organizations to do this job—a job which belongs to the A.M.A., can be done by the A.M.A. and apparently is going to be done by the A.M.A.

In our opinion there should be no unnecessary delay in getting the Washington office started, although we realize that a project of this importance can not become an accomplished fact over night. As already intimated, this action is not only encouraging but also additional justification for our belief that medical organization has the brains and the energy to remain as the leader of and spokesman for the medical profession.

Lest the individual physician get the idea that he can now relax because there is going to be an office and a staff in Washington, permit us to warn that those in the ranks still constitute the real nerve center of medical organization. That office will have its limitations. It will not be able to perform miracles. It will not amount to as much as a thin dime unless it receives active support and cooperation from local and state medical societies and from members of the medical profession at large. The chores will have to be done back home by local and state units and by the individual physicians. All the office in Washington, or any other place, can do is to supplement what goes on back home as it will have no choice but to be responsive to the will of the majority of the membership as expressed through action on the part of local and state societies and the House of Delegates of the A.M.A.

PUBLIC APPROVES AND WANTS PREPAYMENT MEDICAL PLANS

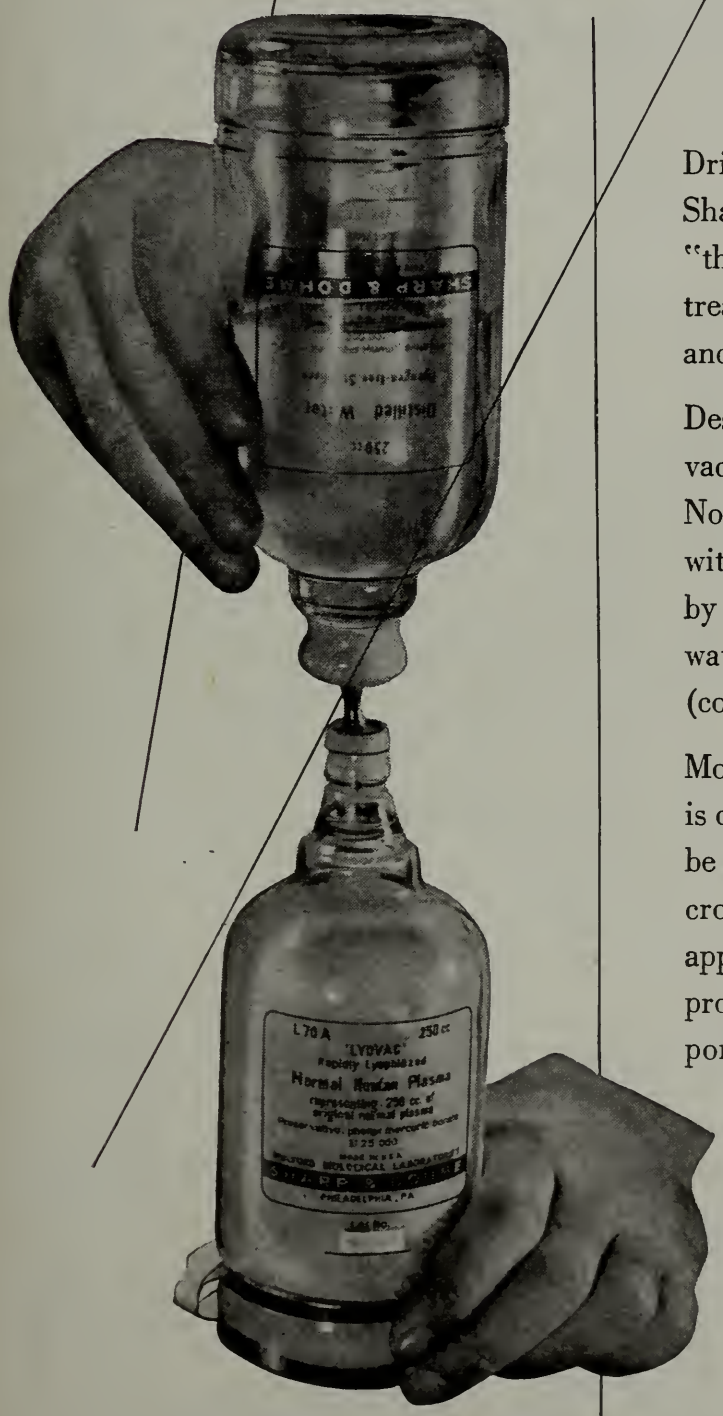
A public opinion survey conducted for the National Physicians' Committee, the results of which have just been revealed, was the subject of an editorial in the March 11 issue of *The Journal of the American Medical Association*. Read it as it is important and worthwhile.

In our opinion, one of the most significant paragraphs of the article was the following:

"Out of this report came the conviction that many persons find difficulty in meeting bills for unusual or prolonged illness and desire to participate in plans or methods for insurance against the hazards of emergency illness. Already great numbers of people are familiar with the various prepayment plans for medical service available throughout the country. The investigations extended into many communities in which such plans are operating and covered the experiences of the participants. To summarize the many questions asked on this phase of the report: Persons who participate in prepayment plans approve them; in every instance such persons believe they

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Sharp & Dohme, Philadelphia 1, Pa.

1. Military Surgeon, 90:306, 1942.

'LYOVAC' normal human PLASMA

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are better off than their neighbors who have no such opportunity; the doctors in areas where such plans are in operation believe that the people are better off because of the operation of the plan. More than 50 per cent of the doctors in such areas stated that it would be a good thing if all industries would operate prepayment medical and hospital service plans for their employees."

If that isn't a challenge to the medical profession, what is it? Those who say the public doesn't want to budget the costs of medical care through prepayment plans are talking through their hats. Those who say the medical profession shouldn't experiment with such programs are not following public opinion. Those who say the job is being done by regular insurance companies are misinformed. Perhaps the job should, and can, be done by regular insurance companies but the fact remains that they are not reaching many persons who want this kind of coverage. The survey indicates that action is indicated and necessary.

P-T SUMMER ROUND-UP DESERVES SUPPORT OF ALL DOCTORS

Each year *The Journal* has urged the physicians of Ohio to cooperate with the Ohio Congress of Parents and Teachers in furthering its Summer Round-Up—the physical examination of pre-school children. Assistance of physicians for its 1944 Summer Round-Up has been solicited by the Health Service Department of the Ohio Congress of Parents and Teachers and we hope that as many doctors as possible will actively cooperate. In our opinion this is a project which deserves the support of each county medical society and the arrangements for assistance should be worked out by the society on the basis of local conditions.

One of the objectives of the Parent-Teacher group is to encourage the building of positive health and the Summer Round-Up is one of the projects in this broad program.

We heartily endorse the comments of Mrs. L. D. Martin, Toledo, health director of the Ohio Congress of Parents and Teachers, with reference to this particular program, believing that this is a worthwhile activity which should be guided by the medical profession and participated in by all physicians.

"In this war-torn world", writes Mrs. Martin, "there is one truth which, to all good citizens of our democracy, remains self-evident—whatever happens to us, the men and women of this country, our children must be kept safe and strong. 'They are not expendable'. They cannot wait for the war to be won. They must be protected and provided for **now**.

"Because it is a war-time necessity to keep children well, the Ohio Congress of Parents and Teachers has accepted the challenge 'to building positive health'. One of the very good ways to meet this challenge is through the Summer Round-Up.

"The physical examination of these five-year-olds who will enter school next Fall and the correction of defects found, together with proper immunization against communicable diseases, will give them an excellent start on their journey through the school years, will help keep the community free from epidemics and will pay dividends to the more than busy doctors and nurses, as well as the parents, the community and the children themselves.

"We again ask the cooperation of the doctors of the state that this project may be carried out successfully. We are grateful for the splendid response received from the medical profession of the state through the years and we hope to receive its continued support."

Doctor, this is a challenge to you! We too solicit your support of this program.

HOSPITALITY AND ASSISTANCE FOR RETURNING MEDICAL OFFICERS

What we thought was an excellent suggestion reached the desk recently, so we'll pass it along to County Society officers. It was that each County Medical Society should have a committee to get in touch with returning medical officers, especially those separated from the services, assist them in getting readjusted for resumption of practice, and welcome them back to the old home town.

May sound like a trivial matter but reflect for a minute on how it might make you feel after two, maybe three, years' absence to have a group of old colleagues call on you, give you the glad hand and offer to help you in getting back into the harness.

Wouldn't be a bad idea to apply the same technique to medical officers home on leave as they too might appreciate knowing that the fellows at home are interested in them. There would be lots of things which the committee could do for them while they are home on a short visit.

A new committee isn't necessary—it's something which the War Participation Committee could handle.

CLASSIFIED ADVERTISEMENTS

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WAR NOTES

Formerly chief of EENT at the McCaw General Hospital, Walla Walla, Wash., Lt. Col. Claude S. Perry, Columbus, now has a similar assignment overseas with the 76th General Hospital. The commanding officer is Col. Paul S. Fancher, a native of Delaware, who has been in the Regular Army Medical Corps since his graduation from Ohio State University College of Medicine in 1930.

* * *

In previous issues of the Journal there have been several War Notes concerning Capt. W. E. McKee, Bryan, who was taken prisoner about a year ago while in action with the First Armored Division in Tunisia. We now have a postal card from Capt. McKee, dated May 23, 1943, received at the State Headquarters Office on March 2. It reads as follows:

"I am unwounded prisoner of war, in central Italy. Would you make inquiry and if possible forward my copy of State Journal to me at this address. We have few books and no technical literature. This is hosp. and the staff receive British Medical Journal three or four months late. Surely appreciate it. Regards and thanks."

Unfortunately, censorship regulations will not permit sending the Journal to Dr. McKee, much as we'd like to do it. A letter has been sent to him expressing the good wishes of his Ohio associates. We hope that he will be recaptured ere long, and restored to our mailing list.

* * *

Capt. Sidney Katz, Cleveland, with an auxiliary surgical unit, writes that he has seen much of England during the past six months. Major Oscar Turner, Cleveland, and Major Frank E. Hamilton, Columbus, are with the same unit.

* * *

A general hospital unit, now in England, has a number of other Ohioans on its staff, according to Major Sander Cohen, Cincinnati. He mentions: Lt. Col. Roy Thompson, Cleveland, chief of X-ray service; Lt. Col. Elmer Rodenburg, Columbus, chief of EENT; Major John E. Brown, Jr., Columbus, chief of the contagious and isolation section of the medical service, and Capt. Tom Curran, Columbus, chief of the general medical section of the medical service.

* * *

Major Joseph B. Edelstein, Toledo, is with an Engr. Combat Gp., "somewhere overseas".

We'd like to use some "art" in the War Notes Section, not a la Esquire—because the Post Office Department won't go for that. Your colleagues, both in and out of the service, would like to see how you look after a session in Uncle Sam's Army or Navy. Because of space limitations, it is not feasible to use individual pictures. However, we might be able to use a group now and then. Scattered throughout the country and across the seas are many outfits to which several Ohio physicians are attached. So get your Ohio gang together, have the Signal Corps or Photographic Section take a shot and then send us a glossy print.

From an island "Somewhere in the South Pacific", Capt. William N. Eberle, Ashtabula, writes: "Have enjoyed the *Journal.* Keep it coming."

* * *

A similar request comes from Major John F. Cronin, Cincinnati, 185th Med. Bn., Separate, APO 183, Los Angeles.

* * *

Capt. A. Arons, Cleveland, after a year in the field with an infantry division, welcomes a change in assignment to the 96th Evac. Hosp.

* * *

Another Ohio physician in North Africa is Capt. J. Cava, Mingo Junction, who is located in a replacement depot. He V-mails: "Enjoy my work very much. We process troops and reclassify and reassign them according to their physical condition, which frequently changes after they leave the States. Some battle injuries are reassigned. We see many interesting cases, and I don't regret the assignment here."

* * *

Capt. Howard H. Minor, Steubenville, is at the Station Hosp., AAF, Ft. Worth, Texas.

* * *

From "Somewhere in England", where he is with a medical battalion, Major Milo B. Rice, Pandora, writes: "There is another officer from Ohio in our unit—Capt. Wm. Chaikin (Cleveland). We both get the *Journal,* and all the medical officers read it and we read their state journals. It's about all the medical literature we have over here and keeps us posted on what's



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going on back home. 'War Notes' are followed closely, and the more you publish, the better it suits us."

* * *

Enjoying a 30-day leave with his family in Columbus is Major Thomas V. Kolb, who practiced in South Charleston prior to entering the service with the 112th Med. Reg., 37th Division, in October, 1940.

* * *

Major Walter E. Yingling, Lima, reports that he has done a lot of traveling since he left Ohio. He says: "Am well acquainted with the life of a nomad. Have seen quite a bit of Africa, in fact, about all I care to see. Have run into quite a few men from Ohio—which is always an occasion for 'do you know—from Columbus or what not?' Spent a couple of months with Capt. J. R. Janney, North Baltimore. Am at present working with Capt. J. R. Herb, Cleveland, and Capt. W. E. Hartman, whose father teaches physiology at Ohio State. Small world you find, when you chase around a while. Certainly have enjoyed my work over here, but Ohio sounds good every time I hear of it."

* * *

Capt. R. K. Ameter, Bryan, writes: "Have been overseas, in the South Pacific area, for about ten months, working as a flight surgeon with an air evacuation squadron. Work is very interesting and we fly a lot and get around plenty. Do not stay in one place very long. Squadron consists of flight surgeons, flight nurse and flight corpsmen."

* * *

Major John C. Drake, Mt. Vernon, formerly stationed at Ft. Bliss, Texas, is now with the 51st Gen. Hosp. Other Ohioans in the unit are: Major John F. Boettner, Cleveland; Capt. Joseph M. Rossen, Lakewood; Lt. Albert E. Flagg, Cincinnati.

* * *

Major A. O. Diggs, Mansfield, with the medical detachment of the 25th Inf., says he is learning a few new things (in an undisclosed location), and the *OSMJ* is still his favorite publication.

* * *

Chief of medicine with a 750-bed station hospital, Major David L. Lerner, Cincinnati, writes: "I have been in England about eight months and have enjoyed getting to know the English, but cannot say very much for their warm beer and lack of central heating. . . . Since the Cincinnati unit moved in, south of here, I feel much more as though I were back in Cincinnati. I can report that they all seem fine and are busy setting up their unit."

* * *

Major T. Arthur Mirsky is at the Station Hosp., AAF, Lincoln, Nebr.

Capt. W. M. Garrett, Frankfort, has been on duty at the Station Hospital, AAB, Presque Isle, Me., for 17 months, "except for a short assignment at an APO near the Arctic Circle". The only Ohio medical officer he has met during that time was Lt. Ed. Artman, Chillicothe, now on duty at West Palm Beach, Fla.

* * *

Lt. Comdr. Thomas E. Newell, Dayton, appears in a picture of medical officers assigned to a Marine regiment in the South Pacific, published in the March 11 issue of the *J.A.M.A.*

* * *

Lt. M. D. Shilling, Ashland, who recently reported for duty at Great Lakes, Ill., joins two brothers in the service: Capt. R. L. Shilling, Ashland, is at the AAFATC, Reno, Nevada, and Lt. M. A. Shilling, Wheeling, W. Va., is a naval surgeon in Hawaii.

* * *

Acknowledging his 1944 membership card, Lt. L. A. Boehm, Toledo, Naval flight surgeon in Hawaii, writes that he and Capt. Harold Ziegler, also of Toledo, attended the funeral of another Ohio colleague, Capt. John Carnes, Gallipolis, who was killed in an airplane crash on Dec. 10. The three Ohioans had just previously been talking about arranging a get-together of Ohio physicians in that area.

* * *

Capt. Ross Zeno, Akron, has hopes of coming home sometime this year after two years in the South Pacific.

* * *

Among the Ohio physicians reported to be members of auxiliary surgical groups in the European theater of operations are: Major A. J. G. Kuehn, Toledo, Capt. Frederick T. Merchant, Marion, and Capt. Vernon A. Noble, Lima.

* * *

No doubt echoing the feelings of many of his colleagues, Capt. R. D. Campbell, Mansfield, with the 111th Gen. Hosp., Fort Knox, Ky., says: "The more I get about this country, the more I realize that Ohio is quite a state. The man who wrote 'Beautiful Ohio' felt very much the same as I do now." Major Charles F. Good, Cleveland, is in the same unit.

* * *

News about Toledo medical officers. . . . Capt. M. W. Selman, after "numerous train rides, an uneventful ocean voyage and many miles of marching" is doing thoracic surgery in England. . . . Also in England for five months Capt. D. L. Friedman, giving anesthetics, reports have seen Major Joe Edelstein. . . . Lucky Capt. A. J. Extejt "captured two cases of real German beer somewhere near Naples", which should have helped him regain the 57 pounds he lost in North

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Africa. He has visited in Salerno, Pompeii, Naples, Capri, Palermo, etc., and just returned to North Ireland after a three weeks' brushing up course in medicine in London. . . . Capt. H. C. Haynie and Capt. Robt. W. Pocotte, are in a hospital unit in Italy. . . . Lt. Comdr. Spencer W. Northrup, who was in Hawaii for two years, has been in the Southwest Pacific for six months in a 50-bed, well-equipped small hospital unit. . . . Says: "We see no white women here except on rare leaves in Brisbane."

* * *

Major J. M. Harsha, Washington C. H., commanding officer of the Sta. Hosp. at Camp Murphy, Florida, writes: "There's nothing new to tell you about Florida, except to say that this year-around summer weather with plenty of swimming in the ocean and fishing is a relief from the cold of the North." (Having just come inside from a typical Ohio March blizzard, we get your point, doctor!)

* * *

Capt. Hall S. Wiedemer, former resident in urology at University Hospital, Columbus, is one of the medical officers in a field hospital on the Anzio beachhead, according to a recent article in the Cleveland Plain Dealer by Wm. F. McDermott, foreign correspondent. Lauding the medical and nursing personnel and patients alike, McDermott wrote:

"The cheerfulness of the wounded, the steadiness, stamina and devotion to their tasks of the doctors, the nurses and the staff in general stick in your mind as something of which Americans and the human race can be proud. They hear artillery fire day and night and the roar of enemy planes overhead.

"Their unprotected tents have been hit repeatedly and are likely to be hit again at any time. It takes stout nerves, firm loyalty, singular selflessness to go about duties that require precision and skill in circumstances so wracking and distracting.

"I imagine that no better medical care is available anywhere in the world than is given in these emergency tent hospitals under gunfire or the risk of gunfire."

* * *

Col. Harry D. Jackson, Circleville, a veteran of World War I, and now post surgeon at Camp Breckinridge, Ky., says: "The good *Ohio State Medical Journal* continues to be a welcome and well-read piece of mail."

* * *

Lt. Col. Johnson McGuire, Cincinnati, is chief of the medical service at the Cushing Gen. Hosp., Farmingham, Mass.

Capt. O. E. Cress, Van Wert, with the 231st Station Hosp., V-mails: "I read the *Journal* regularly and it sure is good to see what happens back in the States. We are kept very busy in our present position. Our hospital is on an estate out in the country and will be a very pleasant place in the summer time. It has not been very cold this winter, but very foggy and damp. We are not close to a very large town, but several small villages. The country around here is very nice and is well kept. They raise lots of vegetables and wheat, also lots of sheep and some cattle, but no hogs."

* * *

On duty at the Hdqrs. of the Sixth Naval District, Fort Sumter Hotel, Charleston, S.C., Lt. Comdr. Howard W. Reed, Akron, is in charge of the Navy's venereal disease control work in North and South Carolina, Georgia and northern Florida. He was one of the guest speakers at the recent Southeastern Social Hygiene Conference in Atlanta.

* * *

Capt. W. J. Slasor, Toledo, is chief of X-ray service at Billings General Hosp., Fort Ben. Harrison, Indiana.

* * *

Lt. Lloyd M. Snively, Massillon, is with the 10th Photo. Rcn. Sqdn., Woodward AAF,. Okla.

* * *

Capt. Owen J. Nicholson, Norwalk, was recently transferred to the Station Hosp., Camp Chaffee, Ark.

* * *

Capt. Leon J. Malock, Youngstown, is at Borden General Hosp., Chickasha, Okla.

* * *

Lt. Comdr. Howard B. Weaver is now on duty at the U.S. Naval Air Station, Peru, Indiana.

* * *

Closer home again is Capt. George M. Wilcoxon, Alliance, surgeon at the Clinton County AAB, Wilmington.

* * *

Dr. Joseph N. Hebble, Springfield, Surgeon (R) USPHS, is stationed at Pine Bluff, Ark.

* * *

Capt. O. J. Fatum, Van Wert, has been transferred to the 306th Airdrome Sqdn., AAB, Pueblo, Colorado.

* * *

After 14 months as post surgeon at the New Orleans Army Air Base, Major Robert L. Eastman, Mt. Vernon, has been made chief of the surgical service of the Regional Station Hosp., McClellan Field, Calif.

* * *

From the island of Oahu in the Hawaiian group, where he is on duty with the 7th Air Force, Lt. Louis L. Weiss, Canton, writes: "You

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have no idea how good it feels to 'belong somewhere'—to have folks back home still think of you as being present when you are far away." Dr. Weiss was at the Tulsa Induction Station for over a year, and in the past four months has been at four separate installations, traveling about 5,000 miles. He has been in on a pass to Honolulu and gone swimming at Waikiki Beach. Apparently not so fortunate is Capt. Bert Seligman, Toledo, also stationed at Oahu, who reports: "Still looking for the spots you see in the movies, but haven't succeeded in locating them yet."

* * *

Life on an island "somewhere in the Pacific" was described by Lt. Charles L. Pfeiffer, M.C., U.S.N.R., formerly of Cincinnati, in a recent issue of the Cincinnati Enquirer. Confirming previous reports about jungle-fighting, Dr. Pfeiffer has this to say:

"When you read in the paper that our forces made a 1,000-yard gain don't poo-poo it at all, for let me tell you that 1,000 yards in this stuff is one hell of a victory. Sherman could drive all the way across Georgia easier than 50 men could pass through any part of this tangle. And something that the movies don't show you, either, or magazines describe, but this jungle stinks with a smell that isn't earthly."

* * *

Major Dan H. Whitacre, Columbus, was home recently on a seven-day leave from his duties as a transport surgeon.

* * *

Recently promoted, Lt. Col. Charles S. Higley is in command of the station hospital, Truax Army Air Base, Madison, Wisc.

* * *

Capt. James R. Moorehead, Seville, is with the 115th Evac. Hosp., Camp Shelby, Miss.

* * *

Lt. David Yospur, Gallipolis, is medical officer with a Ry. Op. Bn., "Somewhere in England".

* * *

Naples, Italy, is the location of Capt. H. H. Gibson, Akron, who is attached to a station hospital. He has been there seven months.

* * *

Capt. Charles W. Edwards, Columbus, is with the 7th Hdqrs., Special Troops, III Corps, Camp Adair, Oregon.

* * *

Base surgeon at the Air Base Dispensary, Miami, Fla., is the assignment of Capt. Louis W. Schneider, Hamilton.

* * *

Col. Theodore Burstein, Canton, writes that his membership card followed him back from Africa. He has been retired (temporarily, he hopes) because of disability.

Capt. William Dreyfuss, Cleveland, is doing surgical urology at the Beaumont General Hospital, El Paso, Texas.

* * *

Comdr. W. M. Johnston, Akron, has been transferred from the U.S. Naval Hospital, Seattle, Wash., to the U.S. Naval Hospital, Great Lakes, Ill.

* * *

Recently promoted, Major Benj. F. Wills, McArthur, is at the Station Hospital, Ft. Benning, Ga.

* * *

Lt. Comdr. H. Vern Sharp, Akron, is attached to a large naval hospital unit in England.

* * *

Major Frank J. Vokoun, Cleveland, has been transferred to the Veteran's Administration, Kansas City.

* * *

Major M. David Burnstine, Columbus, is on the staff of the 59th Portable Surgical Hosp., Camp Livingstone, La.

* * *

Lt. Col. Gordon H. Pumphrey, Mt. Vernon (recently promoted) is at Burns General Hosp., Santa Fe, N.M.

* * *

Major Harry G. Conn, Toledo, is at the Edward Hines Jr. Hosp., Hines, Ill.

* * *

Capt. M. R. Martin, Geneva, is with the 5th Aux. Surg. Gp., Ft. Sam Houston, Texas.

* * *

Col. Edwin J. Rose, Gallipolis, is on duty with the Veteran's Administration, Washington, D.C.

* * *

Capt. Max Sternlieb, Wadsworth, is with the 242nd Med. Bn., Fort Dix, N.J.

* * *

Lt. Ralph J. Starbuck, located at the AAF, 115th Liaison Sqdn., Brownwood, Texas, reports having seen a former Salem colleague, Capt. Robert McKelvey, now at the Station Hospital, North Camp Hood, Texas.

* * *

Transferred closer to home, Capt. Edwin R. Jacka, Bryan, is now attached to the 1373rd Service Unit, Armed Forces Induction Station, Pittsburgh. He was previously on duty at the Sta. Hosp., AAB, Richmond, Va.

* * *

Greetings from the Texas-Louisiana district were received from Capt. U. A. Melaragno, Youngstown, now on maneuvers with the 639th Clearing Co., which is a part of the 241st Medical Battalion.

* * *

Major Samuel L. Greenburg, Steubenville, is chief of the urological section, of the ASF Fourth Service Command Station Hospital, Camp Shelby, Miss.



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In Memoriam

Frank Clemmon Adams, M.D., Yellow Springs; Cincinnati College of Medicine and Surgery, 1901; aged 79; member of the Ohio State Medical Association and Fellow of the American Medical Association; died February 12. After practicing for some time in Madison, Ind., Dr. Adams settled in Yellow Springs and practiced there for 28 years. He was a member of the Masonic Lodge, Knights of Pythias and the Presbyterian Church. His widow and a daughter survive.

Oscar Nels Ash, M.D., Goshen; University of Cincinnati College of Medicine, 1924; aged 47; died February 27. He had practiced in Clermont County for 8 years. Surviving are his widow, a daughter and his mother.

Wesley Willis Beauchamp, M.D., Lima; Starling Medical College, Columbus, 1895; aged 81; member of the Ohio State Medical Association and Fellow of the American Medical Association; died February 26. One of the oldest practicing physicians in northwestern Ohio, Dr. Beauchamp was the first president of the old Lima Medical Society and a past-president of the Academy of Medicine of Lima and Allen County. He had been located in Lima for 32 years and previously practiced in Rockford for 12 years. Dr. Beauchamp attended and presented papers at many medical meetings and had an extensive medical library. He was a former president and councilor of the Northern Tri-State Medical Association. His widow and a brother, Dr. John Beauchamp, Phoenix, Ariz., survive.

William Sherwood Burcher, M.D., Beallsville; Starling Medical College, Columbus, 1895; aged 73; member of the Ohio State Medical Association and the American Medical Association; died February 11. Dr. Burcher practiced in Monroe and Belmont counties for nearly 50 years. He had also been mayor of Beallsville, president of the board of education, postmaster, and an elder in the Church of Christ. Surviving are two daughters, two sons, two sisters and a brother.

Celia O. Clemans, M.D., Westlake; Cleveland University of Medicine and Surgery, 1893; aged 84; died February 13. Dr. Clemans retired about 20 years ago, after having practiced in Canton and Westlake. She was a member of the Congregational Church.

Saul H. Franks, M.D., Cleveland; University of Pittsburgh School of Medicine, 1913; aged 56; member of the Ohio State Medical Association and Fellow of the American Medical Association; died February 24. Dr. Franks was chief resident physician for the Warrensville Infirmary. He had practiced in Cleveland for 30 years. Dr. Franks was a member of the Masonic Order and the Woodmen of the World. Surviving are his widow, a daughter and three sons, one of whom, Dr. Myron B. Franks, is a lieutenant in the Navy Medical Corps.

Delbert David Hamlin, M.D., Marlboro; University of Louisville School of Medicine, 1932; aged 40; member of the Ohio State Medical Association and Fellow of the Americal Medical Association; died February 17. Dr. Hamlin practiced in Marlboro 12 years and was a member of the staff of Alliance City Hospital. He was a Mason. His widow, a daughter, four sisters and two brothers survive.

Charles E. Jewett, M.D., Worthington; Ohio Medical University, 1896; aged 76; died February 23. Dr. Jewett retired about four years ago after having practiced for 43 years. Surviving are his widow and a daughter.

George Lincoln McCullough, M.D., Mechanicsburg; Ohio State University College of Medicine, 1934; aged 35; member of the Ohio State Medical Association and the American Medical Association; died March 2. Dr. McCullough was located previously in Chester. He had practiced in Mechanicsburg for 3 years, and was a member of the Champaign County Board of Health. Surviving are his widow, his mother, two brothers and two sisters.

Russell Haywood Quick, M.D., Toledo; Toledo Medical College, 1897; aged 70; member of the Ohio State Medical Association and Fellow of the American Medical Association; died February 19. Dr. Quick practiced in Toledo for over 40 years. During World War I he was a captain in the Army Medical Corps. His widow and a brother survive.

Andrew Ludwig Reusing, M.D., Akron; Cleveland-Pulte Medical College, 1898; aged 73; died February 23. A former Clevelander, Dr. Reusing had practiced in Akron since 1914; his widow and a son survive.

John Hester Walton, M.D., McAllen, Texas; Kentucky School of Medicine, Louisville, 1893; aged 71; former member of the Ohio State Medical Association and the American Medical Association; died January 15. Dr. Walton practiced in Cincinnati for 43 years, and moved to Texas after his retirement in 1939. Surviving are his widow and two daughters.

Henry Rush Zeller, M.D., Akron; Ohio Medical University, 1898; aged 76; died February 5. Dr. Zeller had practiced in Akron since 1914. He was previously located in Beamsville, Darke County. A son survives.



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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

BUTLER

"Preview of Penicillin", was the topic discussed by Dr. Wm. A. Altemeier, assistant professor of surgery, University of Cincinnati College of Medicine, at a meeting of the Butler County Medical Society, February 24, at the Middletown Hospital.—S. H. Rosin, M.D., secretary.

HAMILTON

The Academy of Medicine of Cincinnati presented the following programs during March:

March 7—"The Diagnostic Implications of Aortic Insufficiency", Dr. Louis Hamman, professor of medicine, Johns Hopkins University School of Medicine, Baltimore.

March 31—"The Present Status of Surgical Therapy in Duodenal Ulcer", Dr. Roscoe R. Graham, associate professor of surgery, University of Toronto Faculty of Medicine, Toronto, Ontario.—Bulletin.

HIGHLAND

Officers of the Highland County Medical Society for 1944 are the following Hillsboro physicians: Dr. J. C. Larkin, president; Dr. J. D. McBride, vice-president; Dr. W. B. Roads, secretary-treasurer; Dr. Larkin, legislative committeeman; Dr. J. D. McBride, chairman, Committee on War Participation; Dr. W. M. Hoyt, chairman, Committee on Industrial Health.—W. B. Roads, M.D., secretary.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

A budget plan for the payment of medical fees was suggested as an antidote to the Wagner-Murray-Dingell Bill by L. John Lee, director of the Medical Business Bureau of Cleveland, at a meeting of the Clark County Medical Society, February 10, at the Shawnee Hotel, Springfield. —News clipping.

GREENE

Among the officers of the Greene County Medical Society for 1944 are the following: Dr. P. B. Wingfield, Yellow Springs, president; Dr. D. F. Kyle, Cedarville, vice-president; Dr. Roger C. Henderson, Xenia, secretary; Dr. F. M. Chambliss, Xenia, legislative committeeman.—Roger C. Henderson, M.D., secretary.

MIAMI

The program for a meeting of the Miami County Medical Society, March 3, at the Piqua Memorial Hospital, consisted of a motion picture, "Riboflavin Deficiency", by Eli Lilly & Company, and an illustrated talk by J. O. Beavis, Dayton, on "Problems Associated with Cleft of the Lip and Palate".—G. A. Woodhouse, M.D., secretary.

MONTGOMERY

Held over for the second month, the movie "Treatment of War Neuroses at Mill Hill Hospital, London, England", was shown at a meeting of the Montgomery County Medical Society, March 3, at Dayton. — C. D. Padan, M.D., president.

Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

AUGLAIZE

Dr. John T. Quirk, Piqua, spoke on "Syndrome, Painful Shoulder and Hand Associated with Heart Disease", at a meeting of the Auglaize County Medical Society, February 10, at St. Marys.—News clipping.

CRAWFORD

"Electric Shock Treatment of Mental Diseases", was the subject of an address made by Dr. George T. Harding, Columbus, at a meeting of the Crawford County Medical Society, February 7, at the Elks Hall, Bucyrus.—Clarence Adams, M.D., secretary.

LOGAN

Officers of the Logan County Medical Society for 1944 are: Dr. R. A. Firmin, Zanesfield, president; Dr. F. B. Kaylor, Bellefontaine, secretary-treasurer; Lt. F. Blair Webster, M.C., U.S.N.R., Bellefontaine, chairman, Legislative Committee; Dr. C. K. Startzman, Bellefontaine, chairman, Committee on War Participation; Dr. A. J. McCracken, Bellefontaine, chairman, Committee on Industrial Health.—F. B. Kaylor, M.D., secretary.

HANCOCK

The following Findlay physicians are officers of the Hancock County Medical Society for 1944: Dr. Henry P. Koehler, president; Dr. E. E. Rakestraw, vice-president; Dr. Lena S. Enright, secretary; Dr. E. J. Thomas, treasurer; Dr. D. B. Biggs, chairman, Legislative Committee; Dr. T. A. Spitler, chairman, Committee on War Participation; Dr. F. M. Wiseley, chairman, Committee on Industrial Health; Dr. Enright, chairman, Committee on Recreation and Physical Fitness.—L. S. Enright, M.D., secretary.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

LUCAS

The Academy of Medicine of Toledo presented the following programs during March:

March 3—General Meeting. "Reports from Our Members Overseas by their Wives", Mrs. Boni E.

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MEDICINE—Two Weeks Intensive Course Internal Medicine starts June 19. Two Weeks Course Gastro-Enterology starts June 5.

GYNECOLOGY—Two Weeks Intensive Course starting June 12. One Week Personal Course Vaginal Approach to Pelvic Surgery starts April 17.

OBSTETRICS—Two Weeks Intensive Course starts April 17 and June 26.

ANESTHESIA—Two Weeks Course Regional, Intravenous and Caudal Anesthesia.

GASTROSCOPY—Personal Course starts April 3, June 19, and October 16.

OTOLARYNGOLOGY—Two Weeks Intensive Course starts April 3 and October 2.

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Petcoff, Mrs. J. M. McWilliam, Mrs. W. A. Baird, Mrs. Richard Hotz, Mrs. Robert Gillette and Mrs. A. J. Kuehn.

March 10—Section of Pathology, Experimental Medicine and Bacteriology. "Prolonged Labor", a round-table discussion presented by the staff of Women's and Children's Hospital, Dr. James Miller, discussion leader; Drs. Robert Baim, J. P. McLachlin, A. H. Steinberg and I. R. Cohn, discussants.

March 17—Medical Section. "Electroencephalography", and "Psychiatric Casualties of Men from Foreign War Zones", Lt. Z. S. Bohn, M.C., U.S.N.R.

March 24—Surgical Section. "Pre- and Post-Operative Treatment of Circulatory Disturbances", Dr. F. C. Clifford.

March 31—Eye, Ear, Nose and Throat Section. "Treatment of Otitis Media", Dr. John A. Lukens; "Lesions of Ocular Fundus of Interest to the General Practitioner", Dr. W. V. Stephenson.—Bulletin.

SANDUSKY

The following physicians are officers of the Sandusky County Medical Society for 1944: Dr. J. C. Boyce, Fremont, president; Dr. A. F. Schultz, Fremont, vice-president; Dr. R. C. Fox, Green Springs, secretary; Dr. E. A. Baker, Clyde, chairman, Legislative Committee; Dr. B. O. Kreilich, Fremont, chairman, Committee on War Participation; Dr. C. A. Kingman, Bellevue, chairman, Committee on Industrial Health; Dr. E. C. Swint, Fremont, chairman, Committee on Recreation and Physical Fitness.—R. C. Fox, M. D., secretary.

Fifth District

(COUNCILOR: E. P. McNAMEE, M.D., CLEVELAND)

CUYAHOGA

The Clinical and Pathological Section of the Academy of Medicine of Cleveland presented the following program on March 3: "Unusual Case of Dentigerous Cyst", Dr. P. J. Aufderheide; "Familial Polyposis of Colon", Dr. S. Frank Weinman; "Ewing Tumor of Vertebra with Neurological Signs", Dr. M. A. R. Hennessy; "Indications for Prostatectomy, Transurethral, Perineal, Suprapubic", Dr. H. R. Trattner; "Thyroid Disease in the Aged", Dr. E. P. Neary; "Observations of Pneumonias Associated with Recent Epidemic of Influenza", Dr. J. Robert Andrews and Dr. Vincent LaMaida.—Bulletin.

LAKE

"Industrial Health", was the topic discussed by Dr. Farrell T. Gallagher, Cleveland, at a meeting of the Lake County Medical Society, February 15, at the Lake County Memorial Hospital, Painesville. Industrial nurses and personnel counsellors from local industries were guests at the meeting.—News clipping.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

COLUMBIANA

Officers of the Columbiana County Medical Society for 1944 are: Dr. Guy E. Byers, Salem, president; Dr. Paul W. Conrad, Leetonia, vice-president; Dr. Ralph B. Vance, Salem, secretary-treasurer; Dr. C. J. Maxwell, Wellsville, chairman, Legislative Committee; Dr. R. C. Costello, East Liverpool, chairman, Committee on War Participation.—Ralph B. Vance, M.D., secretary.

MAHONING

"The Heart in Athletics, Industrial and Military Correlations", was the subject discussed by Dr. John W. Wilce, Columbus, director, Ohio State University Health Service, at a meeting of the Mahoning County Medical Society, March 21, at the Youngstown Club.—Bulletin.

PORTAGE

Dr. John Tucker, Cleveland, spoke on "Heart Disease from the General Practitioner's Standpoint", at a meeting of the Portage County Medical Society, at the Ravenna Hospital, March 2.—E. J. Widdecombe, M.D., secretary.

SUMMIT

Dr. R. L. Rutledge, Alliance, Sixth District Councilor, discussed the Wagner Bill, public relations, and other topics of vital importance to the medical profession, at a joint meeting of the Summit County Medical Society and the Woman's Auxiliary, March 7, at Akron.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

JEFFERSON

The following Steubenville physicians are officers of the Jefferson County Medical Society for 1944: Dr. A. C. Sunseri, president; Dr. J. E. Gamble, vice-president; Dr. D. S. Greenberg, secretary-treasurer; Dr. E. F. C. Sanders, chairman, Legislative Committee; Dr. Fred Harrington, chairman, Committee on War Participation.—D. S. Greenberg, M.D., secretary.

HARRISON

Officers of the Harrison County Medical Society for 1944 are: Dr. E. L. Miller, Bowerston, president; Dr. James F. Toland, Jewett, vice-president; Dr. Dwight C. Pettay, Cadiz, secretary-treasurer; Dr. J. M. Scott, Scio, chairman, Legislative Committee; Dr. Carl F. Goll, Hopedale, chairman, Committee on War Participation and Committee on Industrial Health; Dr. Pettay, chairman, Committee on Recreation and Physical Fitness.—Dwight C. Pettay, M.D., secretary.

TUSCARAWAS

Two members of the staff of Fletcher General Hospital, Cambridge, were guest speakers at a meeting of the Tuscarawas County Medical Society, February 10, at New Philadelphia. Lt. Col. Oscar E. Nadeau, chief of surgery, spoke on



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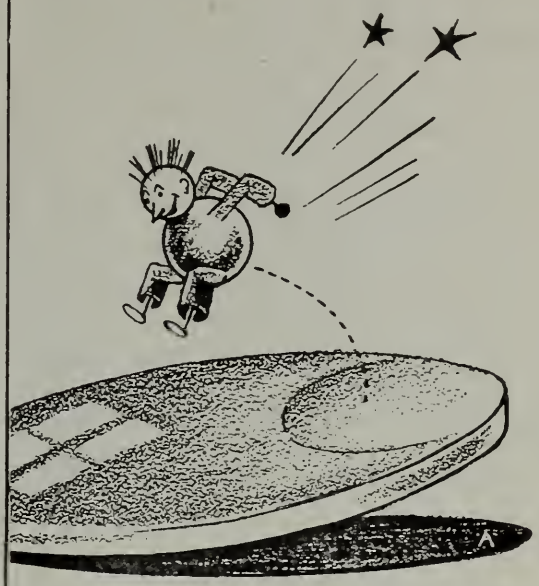
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hospital routine in a general hospital and other interesting details of Army life. Some of the future aspects of tropical diseases and their treatment was the topic interestingly discussed by Major Tibor Benedek, chief of dermatology. —D. M. Ceramella, M.D., secretary.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M. D., PORTSMOUTH)

LAWRENCE

The following Ironton physicians are officers of the Lawrence County Medical Society for 1944: Dr. H. S. Allen, president; Dr. V. V. Smith, vice-president; Dr. H. W. Johnson, secretary-treasurer; Dr. O. H. Henninger, chairman, Committee on Industrial Health, Committee on War Participation and Legislative Committee.—H. W. Johnson, M.D., secretary.

SCIOTO

Dr. V. V. Smith, Ironton, spoke on "Diseases of the Rectum—Diagnosis and Treatment", at a meeting of the Hempstead Academy of Medicine at Portsmouth, February 14.

Members of the society and guests enjoyed a paper presented by Dr. Parke G. Smith, Cincinnati, on "Carcinoma of the Prostate", at a meeting of the society, March 13.—Thomas W. Frame, M.D., secretary.

Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

DELAWARE

Dr. George T. Harding, Columbus, spoke on "The Present Status of Electro-Shock Treatment of Nervous and Mental Disorders", at a meeting of the Delaware County Medical Society, February 15, at Delaware.—F. M. Stratton, M.D., secretary.

FRANKLIN

The following programs were presented by the Columbus Academy of Medicine during March:

March 6—"The Operative Treatment of Certain Psychoses", Dr. Harry E. LeFever and Dr. Roy J. Secrest, with discussion opened by Dr. George T. Harding.

March 20—"Some Common Endocrine Conditions in Children", Dr. A. Wilmot Jacobsen, professor of pediatrics, University of Buffalo School of Medicine, with discussion opened by Dr. Oliver W. Hosterman and Dr. Marion L. Ainsworth. —Bulletin.

KNOX

Dr. I. S. Rian gave a lecture on "Psychiatry" at a meeting of the Woman's Auxiliary to the Knox County Medical Society, March 1, at Mt. Vernon. Donations of $5 to the Seeing Eye organization and $15 to the Red Cross was authorized. The Auxiliary was responsible for sending one cadet nurse to a Columbus hospital for training.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE M.D., SANDUSKY)

ERIE

Officers of the Erie County Medical Society for 1944 are: Dr. C. E. Swanbeck, Huron, president; Dr. E. C. Alexander, Castalia, vice-president; Dr. E. J. Meckstroth, Sandusky, secretary-treasurer; Dr. H. Sarchet, Sandusky, chairman, Legislative Committee; Dr. A. R. Grierson, Sandusky, chairman, Committee on War Participation; Dr. P. N. Squire, Sandusky, chairman, Committee on Industrial Health.—E. J. Meckstroth, M.D., secretary.

ASHLAND

A motion picture, "Diseases of the Adrenal Gland and its Treatment", was shown at a meeting of the Ashland County Medical Society, February 19, at the Ashland Country Club.—Reid P. Joyce, M.D., secretary.

HURON

The following physicians are officers of the Huron County Medical Society for 1944: Dr. C. B. Thomas, Norwalk, president; Dr. R. A. Blackman, Norwalk, vice-president; Dr. John A. Sipher, Norwalk, secretary-treasurer; Dr. G. F. Linn, Norwalk, chairman, Legislative Committee; Dr. H. A. Erlenbach, New London, chairman, Committee on War Participation; Dr. W. W. Lawrence, Norwalk, chairman, Committee on Industrial Health; Dr. J. M. Hindley, Monroeville, chairman, Committee on Recreation and Physical Fitness.—John A. Sipher, M.D., secretary.

LORAIN

"The Veterans' Hospital", was the topic of an address by Dr. W. H. Bradford, chief medical officer, at a meeting of the Lorain County Medical Society, March 14, at the Lorain Country Club. —L. H. Trufant, M.D., secretary.

WOMAN'S AUXILIARY NEWS

FRANKLIN

Capt. P. L. Getzoff spoke on "Community Problems and Venereal Disease Control in Wartime", at a meeting of the Woman's Auxiliary to the Columbus Academy of Medicine, February 21, at the Columbus Gallery of Fine Arts.

LUCAS

At a meeting of the Woman's Auxiliary to the Toledo Academy of Medicine, February 15, the program consisted of brief informal talks by members whose husbands are in overseas service. Among them were: Mrs. W. A. Baird, whose husband is in New Guinea; Mrs. Robert Gillette, South Pacific; Mrs. Richard Hotz, Hawaii; Mrs. A. J. Kuehn, England; Mrs. F. P. Osgood, South Pacific; Mrs. John L. Roberts, New Hebrides; Mrs. J. F. Whitacre, Aleutians and Mrs. Boni E. Petcoff, Iran.

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The Physician's Bookshelf

Body Poise, by Walter Truslow ($4.50. *Williams & Wilkins Co., Baltimore, Md.)* presents a comprehensive study of this important subject. We physicians are inclined to discount the importance of good body posture to optimum health. This book is recommended to bring us back a realization of the fundamental value of good anatomical relationships to good bodily performance.

Medical Parasitology and Zoology, by R. W. Nauss, M.D. ($6.00. *Paul B. Hoeber, Inc., New York City)* presents the essentials which you and I have to get up on. It is a beautiful book as well.

Synopsis of Obstetrics, by Jennings C. Litzenberg, M.D. ($5.00. 2d edition. *C. V. Mosby Co., St. Louis)* is an excellent volume containing new material on the relation of ovulation and conception to the menstrual and ovarian cycles; the blood diseases of gestation; pregnancy diets; contracted pelvis; and the toxemias of pregnancy "more clearly revealed by biochemistry and clinical experience".

A Handbook for Nurses' Aides by Katherine T. Orbison ($2.50. *Devin-Adair Co., New York City)* presents for its public as clearly as is possible in words and pictures the nursing procedures "which must be learned by a nurse's aide". It is very properly recommended by the O.C.D.

Surgical Errors and Safeguards, by Max Thorek, M.D., ($15.00. 4th Edition, completely revised. *J. B. Lippincott Co., Philadelphia, Pa.)* attempts to make a contribution to the young surgeon's judgment by implanting in his youthful mind the lessons of a thousand errors. In this way is his mind matured. With this rich experience and his own increasing education he comes finally to have real surgical judgment. This volume, therefore, should have a place on the desk of the young surgeon.

Fractures and Dislocations for Practitioners, by Edwin O. Geckeler, M.D., ($4.50. 3rd Edition. *Williams & Wilkins Co., Baltimore, Md.)* presents the new development in the field. A practical, worth-while manual as its success would indicate.

Nascent Endocrine Therapy, by John Franklin Ritter, M.D., *(The Caxton Printers, Ltd., Caldwell, Idaho)* presents the author's claims to as successful a control of circulatory hypertension as that of insulin in diabetes; of circulatory hypotension to an even greater degree; and an equal success in the recovery of cases of peptic ulcer. Eighteen of the author's 45 years of practice have been devoted to these researches, the results of which have been "denied systemically and refused investigation by some of our greatest medical institutions". The treatment consists of "nascent" (fresh) endocrine secretion and actual transplants.

Geriatric Medicine, edited by Edward J. Stieglitz, M.D., *(W. B. Saunders Co., Philadelphia, Pa.)* is another excellent contribution to the youngest of our medical specialties. Written by some 55 of our outstanding authorities, it represents an excellent survey of this field.

Unit Medical Records In Hospital and Clinic, by Dorothy L. Kurtz. ($2.00. *A Columbia University Press Publication.)* This unit record system has come to be accepted as the ideal method of keeping the hospital and clinic records of patients. In theory it makes all data about each patient available each time he is under treatment and it preserves all of it together for research. In practice, however, there are a great many problems to be solved before this theory can become a fact.

Doctors on hospital staffs, and even hospital superintendents who are impatient to obtain the obvious advantages of the unit record system are to a great extent unaware of the conditions which must be met before the system will function adequately. It is for such people and also for the record librarians who will be charged with setting up and operating such a system that this book is primarily intended. For those whose chief concern with the unit record is its use as a source of research material, there is a chapter dealing with the collecting and tabulating of such data.

Toxicology and Hygiene of Industrial Solvents, edited by K. B. Lehman and F. Flury ($5.00. Translated by H. F. Smyth and Eleanor King, Mellon Institute. *Williams & Wilkins Co., Bal-*

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timore, Md.) covers the subject in a comprehensive yet practical fashion. The industrial developments of this war have made exposure to solvents our most widespread clinical hazard. This book must be studied by all concerned.

Nutrition in Health and Disease, by Cooper, Barber, and Mitchell ($3.50. 9th Edition. *J. B. Lippincott Co., Philadelphia, Pa.)* is an excellent textbook which has been brought up to date with photographs in color of nutritional deficiencies; a whole new section on vitamins; and a good chapter on wartime problems. In all, a handy volume to have on one's desk, besides being a good textbook.

The Nature and Treatment of Mental Disorders, by Thomas Verner Moore, M.D., Professor of Psychology and Psychiatry, Catholic University of America ($4.00. *Gene Stratton, New York City)* grows out of the rich experiences of its author. The book is helpful no matter what one's training or particular psychiatric beliefs.

Know Your Hay Fever, by A. P. Sperling, Ph.D., with Chapters on Clinical Application by Arthur B. Berresford, M.D., ($2.00. *Frederick Fell, Inc., 386 Fourth Ave., New York City)* is another and successful attempt to present this affliction in a popular fashion. A book which can be recommended to your patients.

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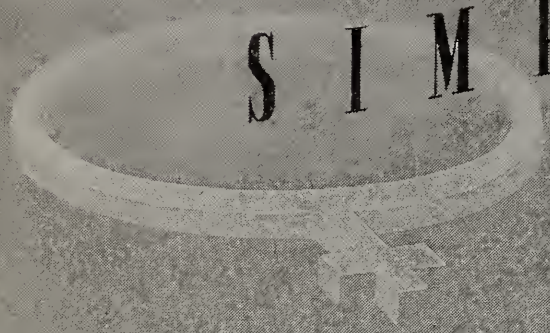




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JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.* GEORGE H. SAVILLE, *News Editor*

Conservation of Industrial Manpower

CAREY P. McCORD, M.D.

IT has been my opportunity to have participated in a number of these state-wide series of industrial medical institutes. To me it seems that each succeeding group of meetings has surpassed all preceding ones. This is as it should be since each new group has been able to avoid the mistakes made in other states.

One of the lessons learned from the Iowa series has to do with the number of talks daily made by some of the speakers. In that good state our small caravan usually started by 7:00 o'clock in the morning, driving some 150 miles; an informal noon meeting with the district medical officers; at 2:00 o'clock there was a more formal meeting; at 6:00 there was the matter of dinner with speeches; then a formal meeting at 8:00 in the evening; a round-table discussion from about 9:30 to 11:00—a few hours of sleep, then a new start to some other city. By the end of one week it was no longer necessary for us to talk about industrial fatigue. Instead we personally demonstrated this condition in distressing form.

In California the necessity for talking was reduced to three, and occasionally we were given a day off for good behavior. Now here in Ohio, with only one formal talk for each speaker, it becomes apparent that orderly betterment is taking place.

A great deal has been said in recent months about the four freedoms: freedom from fear, freedom of religion, freedom from want, freedom of speech. Many persons probably believe that there should be a fifth freedom—freedom from speeches. Since so far this protection has not been provided it is possible that speeches related to the conservation of health of workers are related to a topic as important as any other in these disturbing years.

The Author

● Dr. McCord, Detroit, Michigan, is a graduate of the University of Michigan Medical School, Ann Arbor, 1912; medical consultant, Chrysler Corporation; and medical director, Industrial Health Conservancy Laboratories, Detroit, Michigan.

INDUSTRIAL MEDICINE BELONGS TO THE MEDICAL PROFESSION

Another lesson learned from previous institutes is that industrial medicine illy appreciates the difficulties that attend the general practitioners of medicine in their contributions to industrial medicine. Conversely, the medical profession often has little understanding of industrial medicine at its best. It is an old saying that no dog owner believes that any other person could possibly dislike his dog. Without any intent of evil comparisons, I want to paraphrase that statement by saying that none of us who regularly and wholly function in the field of industrial health conservation can understand that any other medical group could fail to see the tremendous significance of industrial medicine, not only during wartime but in all times.

Sticking to my original figure, on this occasion it is not my function to attempt to dress up this dog, comb out his coat, polish his nails, shine his collar, in order that it might be said: "See what a nice dog we have—you must like our dog." Instead it is my job to do just the opposite—to present this matter of industrial medicine as your

Address presented at series of Industrial Health Conferences at Toledo, Cleveland, Columbus, and Cincinnati, February 7, 8, 9, and 10, 1944, sponsored by the Ohio State Medical Association and the Ohio Department of Health.

dog, at least, your dog as well as mine, in which case all of us will have the proper amount of affection.

The key to all that I shall have to say at this time is that 85 per cent or thereabouts of all industrial medical work long has been, is, and long will be carried out by physicians not directly connected with industry. The reason for this is clear-cut. No one knows the exact number of places of employment in this country, not including farmers, although the general order approximates 2,800,000, but in some 90 per cent of these work places the number of employees may be 10 or fewer. If this be an inexact figure, it becomes possible precisely to point out that 90 per cent are far smaller than may be expected to maintain doctors, nurses or any other well organized medical work carried out on the premises.

As a result, every practicing physician must now be regarded as an industrial physician. On an average 9 per cent to 12 per cent of all of the medical and surgical cases coming to the attention of physicians not in industry are related to work as the direct or indirect cause. These medical matters are so diverse as to reach into every specialty in medicine.

PEOPLE WHO WORK

In this day and time it is almost impossible to determine any nearly exact figure for the total number of persons who are gainfully employed. Compilations available to me variously estimate from 58,500,000 to 64,100,000. This large figure embraces agricultural workers as well as those in military service. For a variety of reasons there are still between 1,000,000 and 1,500,000 who are still unemployed although potentially employable.

A breakdown of manpower figures at the highest level mentioned is as follows:

MANPOWER BREAKDOWN*

	Dec. 31, 1943 (est.)
Armed services	11,100,000
Agricultural	8,900,000
Manufacturing	18,600,000
Mining	1,000,000
Contract construction	1,000,000
Transportation utilities	3,700,000
Wholesale—Retail	5,500,000
Finance, Service, Misc.	4,000,000
Government	5,800,000
Self-employed servants	5,000,000
	64,600,000

*From: Factory Management and Maintenance, Vol. 101, No. 5, p. 86 (May, 1943). "The Changing Manpower Problem" (Editorial).

Through tradition the term "industrial medicine" is chiefly limited to those groups engaged in manufacturing, mining, construction, and at times transportation. In these four groups now are employed 24,300,000 persons. This leaves a larger number of workers engaged in activities little coming within the purview of prevailing concepts of industrial medicine. We are so accustomed to think of industrial medicine in terms of large factories, sizable medical dispensaries on the plant premises and numerous medical personnel serving these larger assemblages of workers that we are prone to overlook that much larger number who may be in department stores, telephone exchanges, butcher shops, banks, and on through scores of other branches of occupation that are only rarely labeled as industry and yet the industrial medical needs of many of these groups may be as great as for those who work in places that we are pleased to label "factories".

Even at a time prior to the war period there were at least 25,000 different ways to earn a wage or salary. With the coming of war enterprise, some of the number may have temporarily disappeared and have been replaced by a much larger number peculiarly related to war production. At least there is justification for claiming at this very time that the number of different ways for making a living in this country is still at least 25,000. In this connection it may be of possible interest to note that the number of different things done in the manufacture of an automobile is in excess of 30,000 and this number starts only when materials in various stages of fabrication are earmarked for the automobile industry. As one single breakdown of this statement it may be noted that over 400 different things are done in the manufacture of the automobile storage battery. For three out of every four occupations there exist, in the absence of due consideration and prevention, one or more opportunities for harm for workers and harm other than traumatic, that do not constitute a threat to the general public.

Whenever I make this statement many persons in the audience may be disposed to challenge its accuracy because harmful exposures are all too closely associated with manufacturing plants, factories, construction, mining, etc. Before you challenge this statement consider the potential exposures of some of these non-manufacturing employments such as the butcher, the barber, the cook, the bus driver, the petty dry cleaner, the sales girl—all have their characteristic exposures and all too many have ill effects therefrom.

SCOPE OF THE INDUSTRIAL PHYSICIAN'S WORK

To the minds of many persons including some physicians, the work of the plant physician is limited to the tedious performance of endless physical examinations and the drab care of injuries, chiefly minor ones, that occur among workers and the making out of reports therefor. To the contrary there is almost infinite variety of situations that make up the daily adventures

of the plant hospital. At some risk of elaborating the obvious it still may be of advantage to list almost at random a sample of current or perennial items confronting the industrial physician, such as:

Is it desirable to carry out preplacement patch tests on new workers exposed to chemicals and other antigens?

Are women workers more susceptible to occupational disease than men?

Why are absentee rates for women almost double those of men?

What medical problems are arising in connection with the re-entry of discharged military personnel into industry?

In view of the distressing increase of allergic manifestations from sulfa drugs should these be abandoned in industry?

What limitation should be placed upon the use of services of the pregnant woman in industry?

What action should be taken in connection with the accident-prone individual?

In view of the debased quality of many scores of solvents used in industry what additional steps may be taken to combat occupational skin disease?

How may industrial noise be best combatted?

To what extent has the six-day week contributed to the incident of occupational diseases?

In the present genuine shortage of physicians, how far should nurses be permitted to go in the making of physical examinations?,

Is work on night shifts more detrimental to worker health than the same duties performed on day shifts?

While major emphasis related to idle machines and empty spaces at the work bench has been linked with absenteeism as will be discussed by Dr. Tallman, it occurs to many of us that in spite of so-called labor freezing, labor turnover is disturbingly significant. The War Manpower Commission has reported that for every 100 workers it is necessary to employ 17 new-hires in order to make a net gain of 3. This represents a wastage of 14 employments for every 100 workers on the payroll.

Five out of 7 of these workers quit of their own accord. Within my personal experience, one worker since July 15 last year has had 13 jobs, at times remaining one day only at a new employment. Disregarding, but not disregarding as unimportant, the medical effort connected with physical examinations, record preparation, etc., perforce there frequently must exist some work environment situations that unfavorably influence this enormous turnover among the newly-hired.

In earlier years the industrial physician working on the plant premises sought sharply to limit his major activities to those worker conditions clearly related to work as the cause. Slowly there has come the realization that the prime problems in a factory, caused by a worker absent on account of pernicious anemia, for example, are not greatly different from those arising from some occupational disease. While the plant physician may not accept responsibility for the care of the first type mentioned, his over-all concern in this non-occupational sickness should not be minimal while maximal for other states more closely identified with work as the cause. It follows that the physician who eliminates a gastric ulcer in an industrial worker in some measure is rendering just as valuable a service to industry as he would in successfully disposing of a case of carbon tetrachloride poisoning.

In the aggregate, those 91 per cent of medical matters unrelated to work as the cause exert a far greater impact on industry than the remaining 9 per cent, but, as another speaker will better present, the days lost to industry because of occupational diseases alone are tremendous. In this state of Ohio in 1942, the last year for which figures are available, 897,012 days were lost by workers on account of occupational diseases—no small portion of the total days lost for both traumatic injuries and occupational diseases which for Ohio alone was for that year 9,611,484. In turn, this high figure becomes relatively small when placed alongside the total number of days lost on account of sickness unrelated to work.

The point to be made is that any good medical service, curative or preventive, extended to industrial workers constitutes good industrial medicine. The conservation of industry's manpower thus involves all of medicine.

All these matters are ably set forth in that small brochure published by the Ohio State Medical Association entitled "Fundamentals in the Organization and Operation of an Industrial Health Program by a County Medical Society". It is likely that every person in this audience has been furnished a copy of this publication. It is scarcely sufficient to say that this is the best of its kind that I have yet seen because there are few or no publications that permit comparison. Altogether I say that it admirably well covers the objective set forth in the title.

THE INDUSTRIAL PHYSICIAN ON THE PLANT PREMISES

As a result of a recent inquiry, some 10,000 physicians in this country listed themselves as engaged in industrial medical practice. This figure in itself means little. In keeping with the trend of this present discussion this figure might have been, instead, 130,000 since in a sense all physicians are industrial physicians. In a more restricted manner this figure of 10,000 is too high insofar as it is intended to indicate the number of physicians carrying out services on plant premises. An exact figure is not known but it probably lies between 2,000 and 2,500 and this will embrace many part-time physicians.

Only about 15 per cent of the 24,000,000 work-

ers making up the earlier mentioned group usually referred to as "industry" are accorded the full-time services of one or more physicians. Thirty-three per cent of these same workers are afforded full-time nursing care. Complementing these two groups are the activities of a fair number of industrial hygienists, dentists, and a large number of safety engineers.

Other things being equal the industrial physician functioning directly on a plant's premises has a tremendous advantage over the physician ministering to workers but apart from plant connections. The essence of this advantage is to be found in the plant physician's knowledge of industry itself. A physician outstanding in medical attainments with scant knowledge of industry's materials, processes, machines and products will be of less worth to industry and industrial workers than a somewhat poorer physician widely familiar with industry. At once three facts stand out:

First, a detailed knowledge of industrial processes and materials such as acquired by the plant physician makes it highly desirable that every sizable industrial plant maintain its own medical department.

Second, Physicians serving industry and industry's workers but apart from the plant premises have an obligation to acquaint themselves in every possible way with industry as such and apart from medical consideration.

Third, the practice of industrial medicine is not the mere carrying out of a general practice on a plant's premises.

HARMFUL WORK MATERIALS

It is granted that the number of harmful work materials that are used in production is almost unbelievable. Different gasses, vapors, mists, dusts, solvents, oils, skin irritants, vibrations, noises, metals, alloys, machines, etc. reach into thousands. In most instances only the full-time plant physician may become acquainted with all of the harmful possibilities even in one plant and yet a precise knowledge of the exact causes of many conditions chiefly occupational diseases and more often occupational skin disease is necessary in order to eliminate or bring under control the disturbing agent.

Herein is the best argument for the full-time industrial physician. It is recognized that the busy general practitioner or specialist rarely may become acquainted with the industrial procedures in the numerous plants that he may serve. In this situation it is enormously important that rash diagnoses not be made and instead that exact information be sought of the plant management to the end that precise diagnoses, so desirable for the workers' interest as well as those of management, may be made.

In order to challenge interest and perhaps a little unfavorable criticism the statement is now made that those in management, without any ill will for practitioners of medicine, tremble in their managerial boots over the distressing attitude of all too many physicians toward real and imaginary work exposures. These physicians see the patient but do not see the plant and its working conditions. Through years of training and experience the physician has come to accept as valid the usual history furnished by the patient. More often than not the management is never consulted. As a result situations both ludicrous and distressing arise to plague industry, occasionally to plague the physician and frequently to disturb the patient.

During the period of preparation of this paper in a certain plant a skin condition in a worker was diagnosed as cyanide poisoning by a well-meaning physician. It was true that this worker was a metal plater but no cyanide plating had been carried out in that plant for a period of seven years, a fact possibly unknown to the patient himself. Obviously, no cyanide dermatitis would persist over a period of seven years in the absence of further exposure. The patient's condition was psoriasis.

In another plant a worker doing upholstering consulted a physician because of a chest condition and properly explained to the physician that his work involved high concentrations of dust. Unhappily a diagnosis of silicosis was made by the physician who possibly did not realize that silicosis specifically is produced by silica and that dust present in an upholstery room almost exclusively is of vegetable origin. It is possibly true that this patient was suffering from asthma on an allergic basis from these vegetable dusts but his physician plunged the matter into the court with a diagnosis of silicosis—to the dissatisfaction of all concerned.

Instances of this sort by the hundred contribute no little to the endless disturbances that unhappily characterize labor relations. The whole situation is thus epitomized: **Every physician is an industrial physician but if he is unacquainted with industry or unwilling to secure exact facts, he may be of dubious value either to the worker or the worker's employer.**

SMALL ADVENTURES IN INDUSTRIAL MEDICINE

It is conceded that a fair amount of the industrial medical work that is carried out is routine—the care of many small injuries, many physical examinations, many minor complaints, many records. Off-setting this little-exciting work is the occasional adventure, the sudden emergency. In the absence of a plant medical department these special problems more often are placed in the lap of public industrial hygiene services, such as that headed up by Dr. Leggo, but at times insurance companies accept responsibility for proper investigation. A recital of a dozen of these happenings would perhaps be more

interesting than much of the material here presented but there is time here only for one.

In a certain plant known to everyone here through much war-time publicity, on a certain Tuesday morning about 30 workers developed an identical skin condition. There were the usual complaints, condemnations, incriminations. The medical department took over. At once it was established that these cases of dermatitis came from no single department, appeared on workers employing highly different chemicals or no chemicals at all, manipulating dissimilar parts, eating in different dining rooms, and apparently in nowise having any common exposure. By the time these facts were assembled, the number of cases reached 40 and the group was a little panicky. It was evident that the condition was no ordinary skin disease, such as scabies, and conversely that it must be a contact affair.

At about this time a common denominator was found. All of these men wore coveralls and all had been furnished clean coveralls on Monday preceding the Tuesday of the outbreak. Here was a clue. This clue further revealed that the points of severest attack were about the heavier seams of the garments and at those points where coveralls were most likely to be in contact with bare skin rather than street garments and underwear. It was then established that all of these workers were wearing garments from a particular industrial laundry.

After that the epidemiology became simple. It was determined that this particular laundry was using a crude turpentine as a dry cleaning agent, turpentine being a good oil extractor. Customarily this oil was removed from garments by seven washings with alkali solution and later plain water, but at the particular time of washing these garments, only 50 per cent of the laundry's work force showed up for duties with the result that these garments were rushed through with only three or four hit-or-miss rinses. The consequences became only too painfully apparent.

This type of problem through endless variation arises in larger establishments and frequently in smaller ones. Far from being drab routine of finger dressing, industrial medicine offers more in small adventures than almost any other field of medicine.

Conservation of industry's manpower is not a problem merely for the war period. Needs existed long before the war and will persist long after. More and more we become an industrial nation. More and more will be the specific, as well as the general, problems of industry. The solution and control of these matters are not exclusively for any small group of physicians called industrial physicians, but instead for the entire medical profession. Toward progress in this domain, a number of little-related suggestions shortly are to be made, some or all of which should be in the minds of organized medicine, as it seeks to shape the avenues of its progress.

TOWARD BETTER CONSERVATION OF INDUSTRIAL MANPOWER

1. Starting with medical schools and training hospitals, students should be better acquainted with industry, industrial medicine and particularly occupational diseases, industrial toxicology and industrial hygiene.

2. Physicians everywhere—being, as they universally are, industrial physicians—should seek to acquire greater information about industry itself, to be utilized along with their undeniable medical qualifications. Without evil intent, a fair percentage of physicians are making themselves ridiculous, bringing condemnation upon themselves, fomenting litigation through insufficient familiarity with well-established and readily-available data in this field.

3. Physicians, industrial management, labor and the public should be concerned with the low order of compensation courts widely functioning throughout the land. Granting that some courts of this character function in a manner above complaint, the others leave much to be desired, and many activities are hurtful to good physicians and factual medicine.

4. Industrial medicine, as carried out on plant premises, instead of being condemned by the medical fraternity, which is not true to any great extent at the present time, should be recognized by the medical profession as a fruitful source of patients. Industrial medicine at its best has little desire for the care of those conditions of non-occupational origin, but is well concerned that such matters receive adequate treatment at the hands of family physicians and specialists.

5. The average practitioner should alter his procedures in relation to many of his patients. Instead of aligning himself solely with his patient and becoming his patient's advocate, industrial matters should be a three-party affair —the patient, as the prime consideration, the physician and industrial management. In almost every uncertain situation, industrial management may furnish factual material tending to clarify nebulous situations.

6. A current situation involves the covering up of work absenteeism under the cloak of medical certificates. It is recognized that there are genuine needs for absenteeism from work. By and large the six-day week is a failure. Every person has genuine need for time away from employment for necessary duties, such as visiting the dentist, the optician, buying objects that require fitting, going to beauty shops, etc. So great is the condemnation of absenteeism that hundreds of doctors are being asked to give plausibility to absenteeism. It is easy to forgive absenteeism,

but it is not easy to forgive the wholesale issuing of medical certificates. As a result, current statistics on sickness are becoming worthless.

7. As a part of organized medicine on every level there should exist committees for the promotion of interest in industrial medicine.

OPPORTUNITIES AND DIFFICULTIES

The star of industrial medicine is rising. Whether it be a laudable specialty of medicine need not here be argued. In either case its opportunities and difficulties remain the same. In the many plans for the socialization of medicine, industry, willy nilly, finds itself as a prospective source of monetary contribution on taxation bases. Without any desire to promote any socialized medicine scheme, industrial medicine is faced with the prospect of much larger responsibilities if, as, and when any of these schemes are put into operation. As industrial medicine stirs with impending expansion, there is every reason not to segregate the small group of physicians carrying out 15 per cent of industrial medicine work, but instead that the entire medical profession, all being industrial physicians, shall undertake the shaping and guiding of industrial medicine to its objectives.

Manpower continues to be the crucial factor in the formula for American war economy. The nation has about reached its limit in the number of persons available to work or fight. So far all too much emphasis has been placed on number, all too little emphasis has been placed upon the best use of those numbers of persons available and notably so in industry.

By no means are all of the opportunities for the effective use of manpower linked up with health. There are still almost unlimited opportunities for technological developments in production equipment and production methods. There are still undiscovered opportunities for the transfer of production from manpower to machinery. No less, one of the truly great needs is for the physical upgrading of people, the provision of the right kind of work places, the right kinds and quantities of food, the elimination of disease, the guidance of sane thinking, the elimination of unholy desires for industrial feather beds.

Those of us long in industrial medicine live in no ivory tower from which excathedra pronouncements may be made as to precise solutions of worker-conservation problems. Speaking in humble fashion, those of us more closely identified with industrial medicine would have you believe that only by the concerted efforts of all of medicine may these ends be attained.

Hallucinations are the audible "echoes" of inner speech projected outwards.—Fetterman.

Better Nutrition in Plant Personnel

We know that there is a difference of opinion on this. We know, too, that the value of vitamin concentrates is well established in the treatment of definite dietary deficiency diseases such as beriberi, pellagra, scurvy, and rickets. No one disputes the usefulness of vitamin preparations in these diseases. However, from the viewpoint of maintaining good nutrition, it seems more sound to strive for a well-balanced daily diet in employees rather than to depend upon the addition of synthetic foods. The emphasis should be placed on an adequate daily consumption of natural foodstuffs rather than a substitution program. The "Nutrition in Industry Committee" of the National Research Council does not recommend the practice of distributing synthetic vitamins indiscriminately to employees by employers.

Another important question concerns the cafeteria. Who should manage it? What connection should the industrial medical department have with it? Our own experience at Parlin may be helpful as an example. In our plant the cafeteria is run by the plant management on a non-profit basis. A hot meal consisting of two vegetables, a meat or fish serving and two slices of enriched or whole wheat bread is offered at the low price of 24 cents per plate. Beverages and desserts are offered at equally low prices. The cafeteria has set up numerous milk vending machines in the working areas. The employees can obtain, at any time, a pint of cold milk for 10 cents. These machines are exceedingly popular, and 1200 pints a day are dispensed through them alone besides the ordinary cafeteria sale of milk, which runs from 300 to 400 pints a day. Our cafeteria also controls mobile units which visit the working areas during each shift supplying sandwiches, coffee, hot soup, soft drinks and desserts. Unfortunately, the latter two articles are more popular than we like to see them. However, this is an educational problem which we will consider later. The medical department inspects the cafeteria about once a month. The sanitary disposal of wastes is especially checked, as are the proper storage of food and general cleanliness. Cafeteria employees are examined twice a year; blood serological tests are taken. The menus are inspected and nutritious foods are suggested. We recently suggested the use of only enriched and whole wheat breads. In general, our relation with the cafeteria has been on a friendly supervisory plane. Our suggestions have always been well received.—C. W. Hoffman, M.D., South Amboy, New Jersey; Industrial Medicine, Vol. 13, No. 2, February, 1944.

Absenteeism and the Doctor

FRANK F. TALLMAN, M.D.

ABSENTEEISM is an old chronic ulcer that has become painfully infected and swollen. It is not a new problem either to industry or industrial physicians, but it is a new "ism" to the rest of us. Under the pressure of necessity industry is making strenuous attempts to find the causes and to apply effective remedies.

The industrial physician when he interprets to management the broad scope and wide application of medical knowledge is playing a useful part in this activity. But those of us whose professional responsibilities are not directly within the walls of a factory have perhaps lagged a bit. Some of us have not clearly defined our importance in the solution of this problem and are not sufficiently conscious that our discipline contains much information that could be used to advantage in putting the right man in the right job and in keeping him performing at a high level of efficiency.

The specialty of psychiatry is a good example of this general thesis and the material that follows illustrates how this organized knowledge of human behavior can be of use in reducing absenteeism. The paper emphasizes the imporance of psychiatric techniques and the psychosomatic point of view in the practice of medicine as well as within the industry organization.

MENTAL HYGIENE PRINCIPLES NECESSARY

No plant can operate smoothly and successfully without basic mental hygiene principles and techniques although few realize that they are operating in the realm of the dynamic forces that are personality. For example, safety engineers are interested in emotional forces that so often cause accidents. So, too, employment and placement people have found that psychometrics are not the panacea that they had once hoped, and they are studying the dynamics of behavior.

Some plants have increased production and cut down absences by getting the workers interested and enthusiastic about their jobs. The more progressive industries are slowly realizing that man can not be separated from his environment and that his attitudes, his emotional difficulties, and his prejudices have to be reckoned with at his place of work just as they are to some extent at home and in the community. Some industries are on the way to adopting this point of view, which, by the way, is implied in the concept "psychosomatic medicine".

The tendency is apparent in plants where the medical department has wide influence among the various divisions concerned with the handling of personnel, and is most noticeable where management has recognized the industrial physician as one who knows about human behavior and can, therefore, help in the solution of problems involving personnel.

MANY FACTORS INVOLVED

Absenteeism is a complex problem involving many factors, some more or less generalized, but others peculiar to the individual absentee. The industrial physician will find that his most useful contribution will be through setting up machinery to remove the enemies responsible for these individual absences whether they are physical or psychological, or both. Each absentee who reports sickness as a reason for being away should be studied in order to remove, when possible, the cause and, as important dividend, to compile reliable statistics. There is no need of a personnel department worrying about diagnosis if the medical set-up functions properly.

Physicians in private practice quite properly have a somewhat different approach to the problem of absenteeism. To them the employee is primarily a patient and attention is upon the disease syndrome presented. It may not occur to them that they are dealing with an absentee from an important war industry and that the course and perhaps the cause of the illness has a direct relationship with the employment environment due to emotional stresses that are present. There are supervisors whose attitudes are perfectly capable of causing gastric ulcers. There are others who might well be held responsible for an attack of mucous colitis or spastic constipation. Too much emotional strain

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may hasten the failure of a decompensating heart or bring confusion to the arteriosclerotic.

There is no doubt that those who are absent from work because of real or fancied ill health are as much the problem of the physician in private practice as they are of the physician within the plant. Both should work closely together and both can favorably influence the trend of absenteeism by utilizing the psychosomatic point of view. This means that the patient's emotional environment and personality make-up have to be taken into consideration when one considers the etiology, symptomatology, and treatment of the human ills. This approach will bring about earlier rehabilitation and consequently quicker return to the job.

FIGURES ON ABSENTEEISM

It is difficult to secure reliable statistics relative to absenteeism, because each company has its own way of auditing and many concerns do not record enough facts to make their information of much value. However, it seems that somewhere between 75 and 85 per cent of the absences due to sickness are unrelated to occupation. It would appear also that the larger portion of these absences are short term, lasting not longer than five days and usually from one to three days. Women have about two and one-half times the sickness rate of men. This is important, because large numbers of women have entered employment due to war pressures and high wages. A further interesting fact is that about three times as many employees in the 60 and up age group are absent because of illness as there are in the 20 to 29 age group. This emphasizes the present importance to physicians of the so-called "wearing out" diseases, because more and more older people are being employed.

Casualties due to occupational accidents resulted in 18,500 deaths in 1942. It cannot be too frequently emphasized that each accident, no matter how serious, should be carefully studied from the standpoint of etiology. It is just as important to know why a worker got hurt as to know how he got hurt. To illustrate this point, two groups of employees whose physical and mental condition make them readily susceptible to injury will be discussed.

The first includes those who have epilepsy and arteriosclerosis. These conditions all predispose to an occasional interruption of consciousness. Undetermined numbers of employees suffer from undiagnosed petit mal epilepsy. Frequently the subject is only aware of what he calls "dizzy attacks" or "forgetfulness". I recently talked with a toolmaker whose foreman had accused him of carelessness and inattention to duty. This man has been having two or more petit mal attacks per day, and why he has not lost some body appendage in the complicated machine that he operates is a mystery to me. He was advised to consult his physician who arranged for a different job placement and prescribed suitable treatment.

Cerebral arteriosclerosis causes periods of confusion which come and go more or less with the rise and fall of blood pressure. A case comes to mind of a maintenance department employee who found that working on ladders made him dizzy. After a number of unpleasant interviews with his supervisor he was sent to the medical department where he was told that he needed a rest. This advice happened to be good, although the patient was not told why nor was a reasonable health plan worked out. Thus he became an absentee for a few days, but in due course went back to the same job. During a period of confusion he dropped a pail of paint off his ladder liberally splashing a junior executive. Things began to happen, and now he is on a job that does not involve ladders nor require effort beyond his strength or his arteries.

EMOTIONAL STATE AS CAUSE

The second group have an emotional state as a causative factor. They include those usually referred to as "accident prone". Many of these have a compulsive need to become injured much as kleptomaniacs have a compulsive need to steal. Closely allied to this psychological problem are those whose phobic state makes it impossible for them to wear masks or goggles. There are employees, too, who have deeply buried hostility to authority and unwittingly get into an accident to have revenge on a wife or a foreman for a real or fancied wrong. A classical example is the case of the school janitor who left his job for a better paying one in a war factory. On the second morning of work he contrived unwittingly to break an ankle. A study of the case showed that he changed occupation only after long, loud persuasion from his wife. He is back doing a good job at the school and seems to be taking good care of his legs, now that he has demontrated that he was right the first time!

Anxiety states are a safety hazard. A worker came in the other day for a Selective Service check-up. In talking about his work he remarked that nothing in the war could be more terrifying to him than the complicated machine he was operating. He described vividly how the various parts of the apparatus bit into the mental gouging out grooves, boring holes, and doing all sorts of awful things all at once. He recounted how each time the tools began to scream at their work on a fresh blank it made him think of how frightened he used to be when his mother shouted and bellowed. As he talked he became more and more tremulous with his anxiety, and indeed it is really a miracle that this man has not been destroyed. Apparently

the machine released his unconscious fears that had been locked away since childhood.

Enough has been said, I think, to illustrate the importance of studying the individual who has been hurt from all angles and not merely from the particular injury he received.

BREAKDOWNS COULD HAVE BEEN AVOIDED

Industry recognizes that employees frequently attribute their absences from work as due to illness, but nevertheless it is a fact that a large number of manhours are lost because of sickness and disease. Some of these breakdowns could be avoided by intelligent placement and close cooperation between the physicians in the community and in the plant. This is particularly true of the diseases peculiar to older people. It should be remembered that most people over 50 have a good deal of work left in them provided they function within their physical and emotional limitations. Employing such a person demands that he be placed in an activity that takes these factors into consideration. Failure to do this results in too many vascular accidents to brain and heart.

A point worth remembering is that it is not enough to tell a patient that he must limit his activity. This obligation is not discharged until a reasonable work plan has been emotionally accepted by the employee and the personnel department alike. A telephone call from the community physician to the plant medical department may save a life, prevent an accident, or forestall absences.

It is important also to keep in mind the early signs of overwork among arteriosclerotics. These are irritability, emotional instability, headaches, dizziness, and periods of mild confusion. If these danger signs are heeded, lives will be saved and too much absenteeism avoided.

DIGESTIVE DISORDERS AND EMOTIONAL PROBLEMS

Digestive disorders, a frequent reason to stay home, are closely linked with emotional problems. The aggressive, tense, anxious individuals are the susceptible type. Personality study of these people usually reveals a deep-seated fear of inadequacy, a standard of performance all out of proportion to reality, and an overpowering, punishing conscience. Certainly an individual with that type of emotional problem and an ulcer in his stomach, is no cheerful, single purposed producer of the sinews of war.

These psychosomatic disturbances are difficult to treat, because they involve psychotherapy, a term which, by the way, frightens most physicians and terrifies surgeons. All doctors use psychotherapy, but they could use more of it and that more skillfully if they kept the mental side of disease in mind. Mental health principles are really not complicated and some of the techniques which are useful in treating the emotions can be readily acquired. Do not let psychiatrists' terminology discourage you. It is just another smoke screen, something similar to the one the dermatologists use.

POST-ALCOHOLIC STATES

Next for discussion are the post-alcoholic states. They account for a large share of absences both voluntary and non-voluntary. The average physician is not in a position to control this very difficult sociological problem, but he should keep in mind some of the more serious causes of chronic overindulgence. Some patients imbibe too freely because only by excessive use of the drug are they able to tolerate life at all; others because they suffer from a very painful depression. They find that alcohol temporarily relieves them of their conscience and thus miraculously of their psychic pain. Some drink to punish aggressive wives, or perhaps supervisors; some drink for relief from the same. Others drink because they are fundamentally psychopathic, and still others because alcoholic bouts are a symptom (similar to kleptomania) of a serious psychoneurosis.

The physician should expect to treat alcoholism by treating the personality and not the stomach. Often an alcoholic career could have been prevented by a little intelligent psychotherapy administered to patient and family by an understanding physician. It should be said, however, that scoldings, pep talks, the extraction of promises, or the cataloging of possible horrendous results is not psychotherapy. It is a waste of time and will not reduce absenteeism by one minute. Too often we become a bit weary and wishfully think that platitudes, cliches, vitamins, and aspirins have truly magical properties, but we should never get so overtired as to expect any therapeutic results from our consulting room lectures.

ABSENTEEISM AMONG WOMEN WORKERS

There are two more groups of diseases that I wish to mention, because they contribute extensively to absenteeism. The first is the problems peculiar to women. The practicing physicians, both in and out of the plant, are in a strategic position to interpret women to their new and frantically alarmed employers. Perhaps some understanding of the problem will lessen the very considerable loss of time that is due to the mismanagement of the physical and physiological problems peculiar to this sex. As an example, absences due to menstrual distress are not inconsiderable.

We all know that some dysmenorrheas are caused by abnormalities of structure and endocrine function. However, even these disabilities

have emotional components and bad days are made worse by emotional distress. But it is also a fact that the gland upset ending in menstruation always causes some degree of emotional instability. We know, too, that some women use this physiological process much as an hysteric does an emotionally initiated physical symptom. Both are painful, but both, nevertheless, have their values.

Menstrual distress is not pleasant, but it can be a handy excuse for being irritable or perhaps taking a day off or for doing as little as possible during working hours. Certainly a woman, if she be calculating, can be a formidable problem to a male supervisor whose mother failed to tell him all the facts of life. Much menstrual distress and wasted time is definitely emotional in nature and comes from ignored fears dating from early adolescence. A doctor with a psychiatric point of view can handle this personal and personnel problem in a manner satisfactory to even a production engineer.

Pregnancy is admittedly a problem to employers. It is unfortunate that it is necessary to adopt a policy of separating a woman from her work at a specified pregnancy month which varies from the third to the fifth. As a matter of fact, there are many women whose emotional adjustment and flexibility of personality make it possible for them to work longer than the maximum, while there are others who are so disturbed by their pregnancy that they become inefficient and a source of trouble. Maternity leaves are good mental hygiene and good business, too.

FATIGUE AND WORRY

Excluding truancy, probably the most frequent causes of absenteeism are fatigue and worry. Both should be considered as an illness. Everyone has certain physical capacity and will, in the end, have to stop work because of exhaustion. This point of exhaustion is reached more quickly when an individual is beset by anxieties, bruised by hostilities, or otherwise emotionally distressed. The physician will accomplish very little by merely counseling his patient not to work so hard. Such advice is usually followed by some such phrase as this, "You'll wear yourself out completely if you keep this up. You ought to know better."

This well meant advice merely increases the distress, because it unfortunately adds more fear to that already present. Much more would be accomplished if the patient were encouraged to discuss his work, so that one could find out if the job was actually too heavy. Perhaps the patient's conscience is overly severe and is of the type that would never be satisfied by any level of production. Many people overwork because of basic insecurities driving them on in search of Nirvana or the pot of gold of rainbow fame. These problems demand some knowledge of mental health for their solution. There is no substitute for this basic knowledge.

We must not forget the importance of noise and light in the production of fatigue. Some are abnormally sensitive to stimuli and therefore can not do efficient work where the machinery is noisy or the lighting faulty. It is a curious fact, too, that some people can not abide silence and do not work well when the room is too quiet. There are more of those among us than might be supposed, as is evidenced by the success of the pre-war campaign, "A radio in every room and two in the car". Physicians would do well to ask their patients about working conditions that are an annoyance.

The industrial importance of our old devil, worry, can not be overemphasized. Certainly this distressing emotional state is responsible not only for loss of vigor at work but also for a great deal of absences from work. We physicians must give critical attention to the worry of our patients. Their anxieties are important and are more often than not disease producing, or at least disease modifying emotions. Personnel and employment directors and supervisors, and safety specialists, have come to realize that the worried worker is inefficient, that he is a safety hazard, and frequently a trouble maker.

SHOP COUNSELING

The solution for this as well as many other health problems, is to set up a practical scheme of shop counseling to help the employee deal constructively with the cause of his worry. Here, again, let me emphasize that telling a patient or an employee not to worry is no more useful than telling him not to drink or to disregard an oft complained of pain.

Industry should be very conscientious in the choice of its counselors. They should be well adjusted individuals who are not going into counseling because they are maladjusted. It is surprising the number of people who deal with our youth in the capacity of deans, supervisors, counselors, etc., who make this choice of occupation because of basic emotional needs and not at all because of their fitness, through experience or training, to do the work. To be of real help one must first be interested in human beings and human behavior. Then, with this attitude as a starting point, one can proceed to determine the apparent cause of the worry and evaluate whether the intensity of the emotion present is appropriate.

It may well be found that some of the misery is due to an ignorance which can be speedily corrected. Some patients will be found to center their worries about their health. They are not really sick; they are frightened by this or that

problem. These need practical advice and psychological medicine. The trick is to define the real problems. It is wasteful to allow yourself to be worn out trying with gallant politness not to hear the endless saga of the worry warts. It really is much easier and more interesting to find out what is behind it all. Skilled psychotherapy will be indicated for the psychoneurotic, but a great deal can be done by any physician who is interested in people rather than syndromes.

However, worries about health, about children, and about finances are all very common, and, all susceptible to solution provided the worker knows where to go to get the needed help or advice. It is not commonly realized how dangerous a worried worker is. His preoccupation and inattention, his mental confusion born of anxiety, and psychic pain make him very likely to cause accidents to himself and others. At least, he does not produce up to capacity. Too much energy is being wasted.

The middle period of life is a time when much worrying is likely to be done. This is because after 50 people tend to review their past. Too often the result is disappointment and dissatisfaction. A look ahead suggests that the life goal will not be reached. All the satisfaction and comforts that have been worked for and daydreamed about seem impossible to secure. The future has become something to fear. This worry is the central core about which is built the so-called involutional states. No doubt some of the man hours lost can be traced to this psychological problem.

RESPONSIBILITY OF THE PHYSICIAN

Worry is thus, a mere colloquialism for anxiety which is a variety of fear, low in intensity but persistently chronic. Physicians are admittedly too busy to do a case work job on every patient, but good medicine dictates that they consciously recognize the influence that the emotions and environment have in the etiology and clinical course of so-called organic disease. Useful, too, would be a more extensive knowledge of the psychology of functional disorders. Indeed, the importance of the use of psychiatric attitude toward the patient can not be overstressed.

It is not sufficiently recognized that the average employee adopts an attitude to his work and the employing company which is definitely conditioned by the emotional experiences that he has had with Joe Doaks, his foreman. His check may be issued by such-and-such a company, but as far as he is emotionally concerned his employer is the same Joe Doaks. Therefore, the more that industrial physicians can share their experience and knowledge about handling people with industry, the higher general morale will be.

It is fortunate that many industrial physicians are getting this point of view and are becoming more and more doctors of men, and it occurs to me that physicians in the community might well follow suit. It is unfortunate the dichotomy, mind and body, is still too much with us. Scientific medicine with all of its exactitudes in diagnosis and treatment has brought with it a sad tendency to think in terms of disease rather than in terms of the patient who has the disease.

TREATING THE WHOLE HUMAN BEING

Since the community physician's responsibility with respect to the problem of absenteeism is centered in his office practice, it is evident that the more successful he is in treating the whole human being, the quicker his patients will get back to work. A shorter way of saying this is to insist that the psychosomatic and mental point of view will result in more successful treatment and consequent rehabilitation. The physician-patient relationship is, when all is said and done, the essence of the practice of medicine.

The physician must ever keep uppermost in mind the tremendous influence and authority that his position gives to him. He must always remember that he is a lay confessor and that he only partly treats a patient unless he takes into consideration the emotional problem present and the difficulties of the inter-personal relationship with which the patient is struggling.

There is nothing new about psychosomatic medicine. Doctors have always, to some degree, recognized the influence of emotions in bringing about physical disease or in modifying its course. Unfortunately this recognition has too frequently been too little and too late. I am satisfied that physicians must guard against becoming mere technicians. They should specialize in becoming comfortable, understanding people again, and perhaps even discard a little of their red leather and chrome. I sometimes wonder if the demand for all sorts of health schemes is not in some part due to the failure of we doctors to practice the patient-doctor relationship that we talk so much about. I wonder if most of us do not need to rediscover the human being.

SOME PRACTICAL POINTS

In conclusion here are a few impudent but practical points:

1. Center interest on the patient first and his symptomology next. Do not take a history let the patient give it.
2. Avoid the habit of thinking phrases such as "I'll bet the woman in the waiting room is a gall bladder".
3. At the first contact allow the patient to tell how he feels about his boss, his work, and his family.
4. Do not do all the talking. If you are quiet

and attentive, you will learn more about the subject and his disease than if you consume your own precious time by delivering a monologue in the form of questions which, incidentally, are often so put that they suggested their own answer.

5. A good psychiatric approach demands: (a) A reassuring, uncritical attitude; and (b) an understanding that the patient is likely to be both fearful and hostile.

6. Remember that the patient does not "think" about his physician but he "feels" towards him. Doctors are in effect emotional substitutes for husbands, wives, fathers, and in fact, all those who have exercised authority over the patient. As a substitute, the physician must be prepared to accept and deal with hostility, rejection, criticism, and very often over-affection.

7. Read journals and books dealing with psychosomatic medicine. They will stimulate your intellectual curiosity and occasionally, but only occasionally, stretch your credulity.

8. Read psychiatry and mental hygiene and keep in mind its application to your own activity or specialty.

9. Do not say, "I do all this," when you mean, "I can't be bothered". Be mentally healthy, face reality.

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Causes of Sickness Absenteeism Peculiar to Women in Industry

We may summarize our findings as follows:

1. Absences and time lost on account of female disorders have not reached an alarming magnitude in our industrial situation, accounting for an average loss of 4 hours and 41 minutes per year for each woman employee.

2. For each 1000 women population, we can expect to send home 28 cases a year because of menstrual disorders.

3. Shop women have a higher frequency of absences because of female disorders than office women, but there is little difference in the rate of time lost between the two groups. Office women, on the other hand, have a higher rate of both absences and time lost because of non-malignant tumors and cysts of the female organs than do shop women.

4. Menopausal absences appear earlier among office women than among shop women.

5. Women in industry are apparently not particularly affected by female disorders.

6. An educational program reaching all women and all family physicians would be of value.—Frank L. Smith, M.D., Chicago, Ill.; Industrial Medicine, Vol. 13, No. 3, March, 1944.

Occupational Disease Problems and How to Meet Them

RUTHERFORD T. JOHNSTONE, M.D.

IN Hans Zinsser's charming biography, "As I Remember Him", is told the story of a field clerk who, having copied a letter in which the word "psyche" was used, remarked: "Ain't that a hell of a way to spell Fish." Just so, M-e-d-i-c-i-n-e is a hell of a way to spell the type of practice, with its many ramifications, that is imposed upon the physician today. Admittedly the horse-and-buggy doctor needed courage, intuition, and a spirit of adventure as he went about the countryside relying upon the laying-on of hands and polypharmacy, without the aid of laboratory tests or the instruments of precision. But was that so bad? At least, his capacity to absorb new ideas was not strained.

Today a myriad of medical periodicals present innovations in practice so prolific as to challenge a doctor's ability to sift the grain from the chaff. Imagine his feeling of futility as he daily enters a hospital staff room to hear his more astute and probably less busy confreres discussing the significance of variations in the fourth lead, the biosynthesis of thiamine in man, the Weltmann serocoagulation band in coronary artery disease, postoperative nitrogen loss, or the effectiveness of testosterone implantations.

Nor did the horse-and buggy-doctor toss each night over the implications of such paranoid legislation as the Wagner Bill. Being busy about a few things constituted his lot, and I, for one, do not think it was so tough when viewed from the present status of what one might facetiously call a medical practice. Contemplation of what medicine will embrace in the immediate years to come initiates frightful cerebrations in the thoughtful mind.

INDUSTRIAL MEDICINE BECOMES OF AGE

One facet of medicine, the surface of which Ramazzini first scratched in about 1700 and which has been polished brighter and clearer in the past several decades in this country by a few persevering pioneers, not the least of them being that noble Irishman of our afternoon program, Dr. McCord, is Industrial Medicine. Struggling through the years with slow and dubious recognition, it took the "brazen throat of war" to proclaim its importance.

Industrial management has now tasted of industrial medicine and found it to be good—good economics. Management has encouraged, and after the war will insist upon, a program the scope of which will startle the uninformed. In addition to the best medical and surgical care, the program includes nutrition, nursing, dental hygiene, elimination of venereal disease, and the early detection of cancer and tuberculosis.

Also of great significance is the adoption by industry of an extensive rehabilitation, or so-called placement program, for the war-wounded and the civilian-handicapped individual. Socio-economic forces are insisting that our profession assume its obligation in caring for the handicapped. No longer will it be sufficient for a physician to prescribe a sedative for the epileptic, idleness for the cardiac, or a prosthesis for the cripple. Industry and you too, doctor, must learn to match job requirements with skill characteristics; to match physical demands with individual capacities. All this, briefly sketched, is the future program of Industrial Medicine.

ROLE OF EDUCATION

It is apparent that such a multiform program demands an army of experienced physicians—experienced in more than traumatic surgery. Nor is a decade of time to be granted to meet the urgency. Postgraduate and undergraduate education must immediately adopt a specific, intensive training of the practitioner and student. In the previous comparison of the horse-and-buggy doctor to the present day physician, the intention was to intimate that a saturation point in learning has been reached.

How then can the subject of industrial medicine as well as new material in general medicine be absorbed under the prevailing conditions? I don't think it can. I think it is time for our medical editors and our medical associations, from the College of Physicians down to the county societies to stop rehashing subjects which all save the indifferent or the stupid have already learned. Nothing new has been learned about certain diseases for the past 20 years, yet these same subjects are as repetitious as hiccoughs on every medical program.

It is time our medical professors devised a

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system of education that will permit the student with obvious clinical acumen to approach his purpose without spending endless hours on subjects he could readily learn, for practical application, in a short didactic course. By the same token, he who leans towards scientific investigation should be granted longer hours in those courses which are curtailed for the student who will go into general practice. "The knowledge which a man can use is the only real knowledge, the only knowledge which has life and growth in it and converts itself into practical power. The rest hangs like dust about the brain or dries like raindrops off the stones." (Froude).

If by this time any of you may be glancing at your program to reassure yourself as to the title of this paper, let me say that the foregoing preachment is not unrelated to the subject assigned. If there are occupational disease problems to be met, as the title suggests, it is absurd to think an occasional program such as this, or a few inadequate voices such as mine, will do much towards solving them. On the other hand, I am obsessed with the idea that it behooves any of us who have an opportunity, to shout loud and often about the need for industrial medical education and the need for a revision of our postgraduate and undergraduate teaching. If you will add your voice to mine and get others to join us, we shall compose a measureless classroom to be reckoned with by our professors.

PROBLEM IS TWOFOLD

To consider more specifically the subject assigned me, the problem arising out of the occupational diseases is twofold. One aspect involves the functions of the physician, whereas the other concerns itself more concretely with the earmarks of these diseases. My discussion of both phases is based upon the assumption that a goodly portion of this audience has had little or no experience with the occupational diseases —otherwise I fear it will be both redundant and boresome.

In common with the diseases of communal origin, those due to occupation require for a diagnosis a good history, a complete physical examination, and a thorough laboratory investigation. Here the similarity more or less ceases. In general medicine it is seldom required of a physician that he prove his diagnosis, but the medicolegal aspects attendant on an occupational disease compel a physician to show his hand. By placing you in a hypothetical situation this can be illustrated, as can a few of the problems to be discussed.

Jones, the butcher down the street, consults you because of increasing fatigue. Your study reveals him to have a secondary anemia. Under the proper treatment he recovers. That is the end of that case.

About this same time Bill Smith presents himself with similar complaints and you find that he too has an anemia. But Bill contends that his illness is due to his work. In answer to your inquiry, he states, "We use some stuff over at the plant called 'Sol X'—the fellows say it has benzene in it".

Being aware that benzene can cause anemia, you are about to report this case to the employer or insurance company as an occupational disease when you decide you are somewhat unfamiliar with all aspects of benzene poisoning and maybe a peek at the literature would help. Sure enough, it states that benzene, frequently called benzol, can cause anemia, but oh, oh—it points out that there is a difference between benz-e-n-e and benz-i-n-e.

You reflect that Bill did not inform you which substance he was handling; that he probably did not know. You call the plant manager but he is uninformed and refers you to the foreman. The foreman states that he has no idea what the stuff is as he had been told to use it only in a certain process. However, he thinks the purchasing agent should know since he bought the solvent. The purchasing agent, however, is of no help. It was sold to him because it could do the desired work, but he was not told of its content. Disgusted with this "run around" you go no further than to send in your report with the diagnosis of occupational benzene poisoning.

Some weeks later you are summoned before the Industrial Accident Commission because the insurance company has contested the claim. Putting you on the witness stand, the company's attorney asked you the following questions:

1. Did you know what ingredients were contained in "Sol-X"?

2. Did you know that an approved exhaust system was employed at the point of operation where "Sol-X" was used?

3. Did you know what the concentration of "Sol-X" was at the breathing zone of the workers engaged in this process.

4. Did you know that Bill Smith did not actually work with or handle this substance, but that he worked in an adjoining room?

5. Did you know that Bill Smith was employed by this company for only two weeks prior to the onset of his illness?

6. Did you know that Bill Smith suffered from bleeding hemorrhoids? (That question left your face red.)

To each of these questions you had to answer, "No; I did not know that".

The attorney then put on the stand a chemist who testified that an analysis of "Sol-X" revealed that it contained no benzene. Next a hygienist described how he had analyzed the content of the air at the point of operation and

found that it contained no noxious substance in concentrations above the permissible limits. A doctor then related that his examination revealed that the claimant had bleeding hemorrhoids. You left the courtroom chagrined and possibly a bit disappointed in yourself.

SEVERAL TRUTHS

Hidden in this hypothetical case are several truths, two of which I hope impressed you. The $64 question is—what **one** word did I use that signifies the basic reason why the occupational diseases constitute a problem? No answers? Stand by, please, for the Jackpot question. The answer is "**unfamiliar**". Now for the Jackpot question. How **can** you become familiar? Not alone from books, periodicals, medical school or postgraduate courses. These, I have insisted, are vitally essential and should be the prelude to an industrial practice. The answer is, however, that by investigation of the plant do you best familiarize yourself with the occupational disease problems.

Has it ever occurred to you that most of us subsist on the dry bread of medicine passed along to us by others? In the long history of medicine comparatively few physicians have ever made new discoveries or enriched the literature with original observations. Many there are who smugly treadmill their span of practice as parasites while others, hedged in by the exigencies of a busy practice, follow the marked trail through gates which have been opened for them by those who have gone ahead. Nor is the opportunity presented to many to be a Beaumont, fortunate enough to observe an Alex St. Martin, or a Jenner across whose path came the cowpox maid.

OPPORTUNITIES OFFERED

In contrast, visualize if you will the opportunities offered the ordinary physician in industrial medicine. Daily new industrial processes are evolved, the effects of which upon man are rarely foreseen. Who could have foretold that an old, presumably innocuous, metal such as cadmium, which has been introduced recently to harden steel, could have its now recognized lethal potentialities? No cloistered hall of science heralded to the medical profession its possible noxious effects, nor did any group of renowned internists describe to the profession the clinical features of an illness resulting from cadmium poisoning. Our knowledge of the noxious effects of this, as well as many other substances, came from lowly but observant industrial physicians.

To continue this comparison, aortic regurgitation is a good example of a dry bread diet. Can you add to the present knowledge of that disease?

On the other hand, it may be possible for you to discover in an arc welder, an old occupation, a type of illness due to his trade that has not been previously recognized. Let us assume in your neighborhood there is a small plant engaged for some years in arc welding. To you from time to time has come the workman with flash burns of the eyes, or metal fume fever, or on rare occasions, one who has inhaled nitrogen fumes. These conditions you have learned to recognize.

Then suddenly, and for reasons not immediately apparent, several cases with deep, resistant ulcers of the upper respiratory tract present themselves. Believing that this is not mere coincidence you go to the plant to investigate and find that a welding rod with a new type of flux is being used. This coating, you learn, contains a fluoride. You recall, or find in the literature, that etchers, enamel makers, bleachers, and others using hydrogen fluoride or its related compounds, develop skin sores or ulcers. You reason that the fumes of fluoride when inhaled and coming in contact with moisture break down into hydrofluoric acid. You suggest a method of prevention or you have a hygienist do so. You thrill to this bit of constructive observation on your part. Still, you recall, others have noted the effect of hydrofluoric acid upon the skin, mucous membranes, and bones. However, you note that little is known about the action of this agent upon the pulmonary tissue. Maybe you could make an original contribution. Your enthusiasm locates several companies in town who employ hydrofluoric acid in pickling baths. These become your laboratory.

Gentlemen, I am not being fantastic. In less opportune circumstances it was this spirit that beckoned Dr. Alice Hamilton up the rickety back steps in the slums of Chicago to learn from its victims what she could about lead poisoning—a climb which never ended until she reached her enviable high position in American Medicine.

VALUE OF PERSONAL INVESTIGATION

This type of personal investigation will provide opportunities that are limitless. Consider the dusts. Today we say that there are only two or three dusts capable of producing a disabling fibrosis. But is that true? Probably not. In time, men such as you will undoubtedly discover new or untried dusty material that can be just as harmful. Suspended in the haze of the industrial dusts, fumes, and vapors are a myriad of obscure, unrecognized dangers to the health of the exposed workman, challenging your investigation.

Osler disposed of clinical speculation and conjecture in favor of the practical method of study when he insisted on making the hospital a medical college. Just so, only when physicians go into the plant to observe and learn will most of the occupational diseases be solved and prevention instituted. This last statement is the crux

of my discussion and nothing remains to be said that equals it in significance.

To this exhortation I anticipate two objections.

First, it can be contended that such investigation would consume considerable time. Certainly it will. But how else in the same amount of time could one obtain a better education? A refresher course of two weeks in Cleveland or elsewhere would involve about 25 or 30 hours —not to mention some expense as well as the loss of income while away from practice. Dividing 30 hours into plant visits of a half hour or an hour, combined with a little reading as new problems arise, would enable one to become well familiar with most of the occupational diseases. It is not expected of you to take dust counts or measure atmospheric concentrations. For such investigation you may call upon the private hygienist or the state, county, or city agencies.

Secondly, it may be feared that as you nose into the occupational diseases you will be required to appear too frequently in court, which is time-consuming and abhorrent to most doctors. Actually, however, the more familiar you become with all phases of industrial medicine the less likely you will be called to court, as will be explained later.

The stereotyped form adopted by most insurance companies and known as the Surgeon's First Report is not practical for use in reporting the occupational diseases. These require a letter, about which a suggestion or two may not be amiss. It is to be assumed that this letter will contain an adequate history of the illness, details of his present and all his past occupations, the findings of the physical examination, the laboratory tests, and the plant investigation. This brings us to the resumé, or discussion of the letter, which, if well done, will save the necessity of an appearance in court.

The discussion should evaluate all the facts and arrange them in such an orderly, logical manner that they will lead the referee of the Industrial Accident Commission to an inescapable conclusion that the claimant's illness is or is not due to his occupation. The discussion should anticipate the contention of the opposition and answer them much as would be done in the rebuttal of a debate. It should include your own investigation of all factors related to the illness in question, as well as an opinion based upon the experience of others, as found in the literature. I grant you that at first writing such a letter is difficult, but experience will enrich your ability and soon this particular problem of the occupational diseases will be performed with facility.

SEPARATION OF FUNCTIONS

There are other medicolegal aspects of an industrial practice which occasion problems and tend to confound the physician. It is the duty of a physician to determine (and only he can determine) if a disease is of occupational origin. It is the function of the legal profession to decide the compensability of a given disease. The separation of these two functions should always be maintained. A physician should not attempt to be both doctor and lawyer, any more than he should permit the law to interpret medical phenomena. It is advisable for the industrial physician, however, to acquaint himself with the meaning and intention of the Workmen's Compensation Act.

To maintain the philosophy of this Act, it is essential that a physician differentiate between the occupational diseases and those considered as risks of commonality.

Claims for chest colds, tuberculosis, eye strain, nervous exhaustion, heat stroke, a callus or blister are usually considered as risks of commonality and, therefore, are not compensable except as resulting from unusual circumstances. Injuries from "horse play" or "sky larking" or assault are not compensable except under rare conditions. Fungus infection of the hands in a shoe clerk may be of occupational origin but not in a truck driver. Pneumonia could be compensable in a fireman forced to get soaking wet in a freezing temperature, but it would not be recognized as occupational in origin in a shoe clerk.

Unless the physician recognizes these points of differentiation, Workmen's Compensation becomes health insurance and its primary purpose is defeated.

One should know the attitude of the law towards pre-existing disease and an aggravation of a pre-existing disease. The recognition of a pre-existing disease, such as diabetes or lues, is essential and should be noted in the preliminary letter or report so that cognizance may be taken of it in the estimation of disability as well as in determining at what point the employer's responsibility ceases in the treatment of the injury or occupational disease.

In most states the Statute of Limitations is recognized by law, wherein six months have elapsed since the date of the last treatment. If, after that date, a claimant who is referred for examination only is given advice, treatment, or a prescription, tolling or extension of the limitations has occurred and is recognized by the courts.

A FEW OCCUPATIONAL DISEASES

Turning to the second phase of this paper, let us consider briefly a few of the occupational diseases. It may be startling to learn that these constitute the largest number of diseases falling into any one subdivision of medicine. Since they are of such numerical proportion, is the diagnostic problem insurmountable? Fortunately not, for the number of clinical entities is consider-

ably less. Furthermore, one is greatly aided in arriving at a diagnosis by keeping in mind a few general axioms:

1. Those portions of the body most likely to be affected by an industrial substance, especially that large group known as the solvents, are: (a) the nervous system; (b) the hemapoietic system; (c) the kidneys; and (d) occasionally the liver. There are exceptions to this rule but they are rare.

2. A short, severe exposure, if death does not occur, usually results in a short temporary disability.

(3) Constant daily exposure to minute amounts of a toxic substance may result in a prolonged, chronic illness.

4. An acute exposure to a substance may affect one system of the body, whereas a slow, chronic exposure to that same substance may affect an entirely different system.

INDUSTRIAL CHEMICALS

A further consideration of the selective action of the industrial chemicals introduces these observations:

1. The disturbance to the central nervous system by the solvents is largely due to two properties that reside within them. The first of these is the anesthetic quality acting in many instances in a manner similar to chloroform, cyclopropane, or acetylene. If the exposure exceeds a mild stage, then narcotic effects are introduced, even sometimes to the point of immediate death. The second frequent disturbance to the nervous system is the result of the ability of the solvents to dissolve fats. Thus, they may act upon the lipoid substance in the nerve fibers, or myelin sheaths, or the cytoplasm.

2. Certain solutions or gases manifest a strong affinity for the hemoglobin of the blood, or cause alteration or destruction of the blood cells. An exposure to arsine, hydrogen cyanide, carbon monoxide, or nitrogen dioxide, may be acutely fatal. Slow, prolonged exposure to certain chemicals, such as benzol, may result in an anemia of inconstant type.

3. In excreting certain of the toxic chemicals the kidneys may be damaged. This is quite often a delayed reaction, as in carbon tetrachloride poisoning.

4. Also the liver, in metabolizing and detoxifying certain of these noxious substances may be affected by constant, repeated assault. The chief chemical offenders are the chlorinated napthalenes, carbon tetrachloride, trinitrotoluene, and one or two others.

CARBON TETRACHLORIDE

With the foregoing axioms and general reactions in mind, let us consider carbon tetrachloride, probably the most widely used solvent in industry. Daily exposure under good hygiene may permit inhalation of minute amounts, which is innocuous due to the normal exchange of oxygen. A short, severe exposure may produce narcosis or unconsciousness since this gas, being similar to chloroform, has an anesthetic effect. But, like being under an anesthetic, the victim recovers quickly and without harm; or, if the overdose is too great, ventricular fibrillation and death may result.

In some instances an acute overdosing may produce latent effects in which the kidneys, or sometimes the liver, are damaged and the picture is that of a severe uremia or hepatitis, or both. The onset of this latent condition is usually a few days to a week. The chronic exposure produces headache, vertigo, increasing fatigue, loss of appetite, gastric distress, nephritis, and sometimes hepatitis with or without jaundice. The accepted rule, then, is that in the sudden severe exposure the nervous system is affected with possible latent effects upon the kidney or liver. But the chronic exposure primarily injures the kidneys and/or the liver, with evidence of a generalized toxemia.

TRICHLORETHYLENE AND BENZOL

Trichlorethylene is likewise a common industrial solvent which in either the acute or chronic poisoning injures the central nervous system as well as the peripheral nerves. The lungs, liver, and kidneys may show changes at autopsy in the acute poisoning but such are rarely affected in the chronic exposure. Carbon disulfide also causes a diffuse neural poisoning.

An example of disturbed hematopoiesis by an industrial substance is that of benzol. In acute benzol poisoning, it is true, there is a destructive or irritating effect upon the central nervous system. These cases are not frequent. The chronic inhalation of benzol fumes results in fatigue, lethargy, loss of weight, anorexia, headache, dizziness, insomnia, epistaxis, bleeding from gums or uterus, and palpitation.

Obviously this condition must be differentiated from pernicious anemia. One cannot place reliance upon the high color index of pernicious anemia for it may occur in benzol poisoning. Erf and Rhodes state that in a differential diagnosis achylia is absent in the chemical poisoning. Early leukopenia was once held as a diagnostic sign of benzol intoxication.

There is now evidence that no reliance can be placed upon this contention but rather that the hematological abnormalities from benzol poisoning run an extremely wide and varied gamut. Investigators have noted anemia, leukopenia, thrombocytopenia, reticulocytosis, high color index, increased fragility of the erythrocytes, urobilinuria, and prolonged coagulation time. The bone marrow may be normal, aplastic, hyperplastic, or leukemic. The variation is due to the

degree of exposure, length of exposure, and individual susceptibility.

ADDITIONAL SOLVENTS

Before disposing of the solvents, mention must be made of one industrial group of chlorinated hydrocarbons called the chlorinated napthalenes and diphenyls, more commonly known under the trade names of Halowax and Aroclor. The resinous or waxy solids from this group find especial usage in radio condensers or in impregnated cable coverings.

Chloracne or "blackhead itch" is a skin reaction from contact with Halowax which will not be described here. In industry the material is handled in several ways; it may be melted in large tanks where it is used to saturate electric products; or mixed with other compounds to form plastics or protective coverings such as waterproofing or fireproofing fabrics. Mayers and Smith report a case of near fatality in a girl who was soldering electrical condensers and inhaling the fumes which came off. Undue exposure to the chlorinated napthalenes results in toxic destruction of the liver. While other vital organs may be disturbed, it is the liver damage which is constant.

To reiterate, if one applies the aforementioned axioms to any industrial illness, the cause should not be difficult to determine. For instance, a severe anemia should lead one to suspect a certain group of substances recognized as capable of altering the normal blood picture. The case in question might be lead or it might be benzol. The next step is to ascertain the exact nature of the substance to which the patient was exposed.

In this respect the case of Mayers and Smith presents an object lesson. Fifteen days prior to admission to the hospital this eighteen-year-old girl developed swelling of the legs, face, and abdomen, along with a loss of appetite, nausea, and a skin eruption. This was followed by a yellowish scleral tinge and muddy appearance of the skin. An acneform eruption over the face, chest, and back developed. The failure of the blood sugar curve to return to the resting level in two hours, the reversal of the albumin-globulin ratio of the blood, reduction in total blood proteins, high icterus index, and low plasma fibrinogen, together with the clinical picture, suggested extensive liver damage. A diagnosis of toxic jaundice was made.

Now, from the extensive and thorough laboratory checkup one can assume that the physician in charge was a well informed clinician, yet here is what he wrote on the hospital record: "Have not been able to find any chemical she was exposed to, or drugs she has taken, to account for the liver damage". The reason that he could not find the chemical she was exposed to is obvious—he did not actually try. He was practicing frockcoat medicine within his carpeted office and in an ultra-equipped scientific hospital. Had he asked himself what industrial chemicals most often affect the liver and then crossed the tracks to determine the exact substance to which this patient had been exposed, he would have arrived at a logical diagnosis.

METAL POISONING

Regarding the metals, I can allot but a moment. Lead poisoning still represents a high incidence in the occupational diseases. I hesitate to mention lead intoxication, since I am in the shadow of the Kettering Laboratory, from which emanates from the pen of Kehoe, Machle, and others, our best information regarding this disease. But since I am a follower of their thought I can hardly say anything amiss.

I can not refrain from reiterating the truth that lead absorption is not to be confused with lead intoxication. This is a frequent error due to the fact that medical schools and textbooks do not correct the prevailing opinion that a lead line and basophilic stippling of the blood cells are evidence of lead poisoning. Even abnormal amounts of lead in the urine and blood are not indicative of lead intoxication unless they accompany clinical manifestations. Some individuals can tolerate high amounts of lead in the body without disturbance, much as some can hold more liquor than others. To determine the degree of absorption it is best to disregard the blood stippling in favor of the urine analysis or whole blood content, or both.

Nor can I agree with the universal practice of giving calcium to store lead. I am not sure that calcium is even a specific for alleviation of lead colic, but if so, beyond that usage it has no utility. I demonstrated this to my own satisfaction in a severe, almost fatal, case of lead encephalitis in which aside from two spinal punctures the patient received no treatment. He made a complete recovery and has had no return of symptoms after three years, despite several severe infections.

CADMIUM

Cadmium must be brought to your attention since it is being used increasingly in industry, for coating bearings, marine machinery, and many metallic fittings where zinc was formerly used. We have no knowledge concerning chronic effects but it is the short, acute exposure which is known to be lethal. Ignorance on the part of industrial management has accounted for many fatal accidents. Uninformed of its toxic effects, men have been assigned, without protection, to weld or cut with an acetylene torch substances coated with cadmium.

While the initial symptoms are irritation to the throat, cough, headache, chills and vomiting in the milder exposures—symptoms which simulate metal fume fever—the more severely ex-

posed quickly develop pulmonary pathology. The significant symptoms of the fatal or near fatal cases are marked constriction of the chest, chest pain, severe dyspnea, and prostration. X-ray films of the chest will show a patchy bronchopneumonia.

Time forbids mention of certain of the older metals, such as mercury or arsenic, or to introduce material about some of the newer metals such as magnesium, tellurium, vanadium, etc. It is possible that in themselves they do not represent a particularly toxic group. However, most of these metals lend themselves to easy alloying, and in such a process there may be as yet unrecognized dangers.

THE DUSTS

The dusts in industry are both prolific and ubiquitous. For practical purposes they may be divided into two groups, namely those which may produce a fibrosis of the pulmonary tissue and which under given conditions proliferate to a disabling fibrosis; or those dusts which are usually inert and only rarely cause any degree of fibrosis. Silica is the outstanding example of the first group. It is capable of producing a silicosis, a disease due to breathing air containing free silica, characterized anatomically by generalized fibrotic changes and the development of miliary nodules in both lungs, clinically by shortness of breath, decreased chest expansion, lessened capacity for work, absence of fever, increased susceptibility to tuberculosis; and radiologically by characteristic X-ray findings. The development of silicosis is dependent upon the size of the dust particle, its concentration, and the length of exposure. Cases developing under ten years of exposure are rare. The etiologic, clinical, and radiologic findings are the essential factors in the diagnosis, of which the clinical are the least important.

Regarding the diagnosis of silicosis from an exposure to a "silica type" dust, it is essential that one differentiate silica from the silicates. The silicates are far more abundant in industry than free silica. Within the silicates, silica is locked or bound by the chemical structure so that it is not released to act as a harmful agent within the lungs. Failure to recognize this difference causes considerable confusion in medicolegal controversies. The only silicate generally acknowledged as capable of producing a disabling fibrosis is asbestos, although recent investigations indicate that the mining of talc may do so. Talc is a silicate containing tremolite and soapstone with no free silica. Just why these two silicates have a similar reaction is not clear but the pathological studies reveal asbestos-like bodies present in both diseases.

It must be remembered that the presence of silicosis does not necessarily indicate a disability. Many individuals with widespread and advance silicosis live to an advanced age without difficulty, only to die of some unrelated disease. Neither clinically nor roentgenologically has there been adopted a uniform classification of the stages of silicosis. Many divide the pathology into simple silicosis with varying degrees of intensity, and silicosis with infection. The infection in silicosis is invariably tuberculosis. Gardner has estimated that 75 per cent of all silicotics die of tuberculosis, whereas Clement, after a ten-year study of the miners in the north central part of the United States, contends that a silica-laden atmosphere does not predispose to tuberculosis and that most silicotics do not develop tuberculosis. Although Gardner's figures may be high, his vast experience and the statistics tend to support him.

SILICOSIS IN OHIO

The ceramic industry in the southeastern part of this state offers a problem in silicosis control. This industry includes pottery, such clay products as brick, sewer pipe, terra cotta, tile, and electric porcelain. It also includes glass, vitreous enamel, refractory and artificial abrasive products. Physicians practicing in the neighborhood of these industries should be cognizant of the varying amounts of free silica in these products. Clay may contain free silica from as little as one per cent up to 25 per cent; glass mixes may contain as much as 60 per cent free silica, porcelain up to 40 per cent, tile body clay up to 15 per cent, and frit to 10 per cent.

In a survey of the ceramic industry, Greenburgh and Hatch list 16 different steps in processing the finished product. While the hazard to silicosis may vary, each phase warrants adequate protection. Nor must one forget the lead hazard in the ceramic industry. It was in the careless handling of frit that my case of lead encephalitis previously mentioned occurred.

INERT DUSTS

Coming to the larger group of dusts, the inert dusts, it can be safely stated that as much confusion exists about the harmful effect of these dusts as there does about silica. Any patient who testifies that his lungs have been affected by working with cement, or lime, or aluminum will find many willing ears in the medical profession. Recently, labor trouble in an aluminum company in Los Angeles incited many claims of what was called dust disease of the lungs. These men presented medical reports which so stated. In some instances no X-ray examination had been made, while in others film marking due to old calcified tuberculosis, bronchiectasis, passive congestion, or even normal linear striations were taken as evidence of pneumoconiosis. I believe the opinions expressed were all honest but nevertheless inaccurate.

An excellent illustration of the harmless effect

of the inert dusts is revealed in the report of the investigation of the cement industry by leaders in the field of silicosis, chiefly the Saranac group. They studied the relationship of silicosis, bronchitis, and pneumonia to the prolonged exposure to cement dust and concluded that such exposure did not cause or predispose the workers to these diseases. Among these workers only an upper respiratory infection, particularly coryza, was more prevalent than in the general community.

I do not wish to infer that a heavily dust-laden atmosphere is a desirable one. I only want to impress the fact that, in general, it can be assumed that an exposure to an inert dust produces no harmful effect upon the lungs and that for any degree of fibrosis to occur takes a considerable number of years. Of course, this generally accepted fact should not deter you from completely studying each case as it presents itself. Since the knowledge of the dusts is far from final, the possibility exists of any one of us discovering a new or unsuspected harmful dust.

DUST AND PNEUMONIA

It is true that many of you may only rarely be confronted with the necessity of determining whether or not a claimant has silicosis or any type of pneumoconiosis. But one problem of the occupational diseases that is almost inescapable is the patient who claims that his pneumonia, cancer, or tuberculosis is due to his working in a dusty atmosphere. Pierpont studied the miners in the hematite ore districts of Michigan and Wisconsin to determine the incidence of pneumonia as compared to males not engaged in a dusty trade and living outside a mining district. This was done over a ten-year period before the arrival of the sulfa drugs. His conclusions are these:

1. The mortality rate from acute lobar pneumonia is less in the counties where iron ore mining is the chief industry than it is in the states as a whole.

2. The incidence of pneumonia among the miners is no greater than in those workers engaged in dust-free trades.

3. The mortality rate among those who had been working underground for years was no greater than for males of the same age who had been working on the surface. To add to Pierpont's conclusions, the incidence of pneumonia among cement workers was no greater than in the general population as determined by the Saranac investigation. Haythorn and Meller found no evidence of a relationship between the incidence of pneumonia and anthracosis. Welders frequently claim that their lungs have been affected by their trade. Excepting the acute irritations that might result in metal fume fever or from nitrogen fumes, there is no evidence that these workers undergo any gross pulmonary pathology. It is true that after many years of exposure these workers may develop spots on their lungs due to iron pigmentation. Sander, of the Industrial Hygiene Foundation, recently confirmed from his intensive investigation the observations made for some years by other men that this siderosis consists of inert pigment deposit in the lympathatics, without fibrous proliferation and without progressive changes after exposure is materially decreased. Experimentally this fact was substantiated separately by McCord and Gardner.

Nor are welders more prone to pneumonia than other groups of workers. Those who have studied this claim say that the so-called welder's pneumonia is a misnomer. Collen, Dybdahl, and O'Brien investigated the incidence of pneumonia among the shipyard workers on the west coast and concluded that pneumonia is no more apt to occur among the welders than among other workers in the shipyards.

INCIDENCE OF TUBERCULOSIS

Regarding the incidence of tuberculosis among industrial workers, especially those of the dusty trades, there is ample evidence that except for those with silicosis, dust is not a factor in the production of tuberculosis. In 1941 a national symposium composed of the leaders in all types of industry was conducted to determine the influence of various trades upon the production of tuberculosis. The conclusions reached from this authoritative group were these:

1. It is clear that there can not be tuberculosis without the tubercle bacillus; that the source of the bacilli is almost always individual.

2. Except for certain exceptions, breakdowns are not due to environmental factors in industry.

3. The standard of living is the main environmental factor. Of the industrial exposures, free silica is the only one accepted without a challenge. Of the dusts, only high free silica dust offers a change in the incidence of tuberculosis.

As to cancer, it can be safely stated that a dusty trade is not the cause of pulmonary malignancy. In Hueper's large monograph on "Occupational Tumors and Allied Diseases" he has collected the figures from Europe, the Johannesburg mines of South Africa, and from America. These are all conclusive to the point that silicosis, siderosis, and other types of pneumoconiosis do not give rise to pulmonary malignancy. He did exclude asbestos from this group, stating that the data in this regard was not sufficient to form an opinion.

Finally, I wish to point out that a certain portion of our profession constitute a bottleneck to the solution of the occupational disease problem because of their attitude. These uptown specialists look with disdain upon industrial medi-

cine, yet when the occasion arises commit themselves to an opinion that is neither of knowledge within their own experience or to be credited by the experience of others. Such—shall we forgivingly call it—thoughtlessness contributes two false bits of fabric to the occupational disease pattern.

BOTTLENECK TO THE SOLUTION

First, it confuses the medicolegal issue; and secondly, it adds erroneous aspects to a clinical entity. For instance, a claimant who had been exposed to negligible amounts of carbon tetrachloride developed a coronary thrombosis. A cardiologist testified that he thought this exposure could have induced the cardiac pathology. When questioned for an authority he stated that he recalled seeing in the *J.A.M.A.* an article that mentioned carbon tetrachloride and heart disease.

Bear with me a moment while this most careless assumption is analyzed. He had seen an article in the September, 1943, issue of the *J.A.M.A.* which discussed the therapeutic effects of certain gases and solvents and considered the possibility of excessive amounts producing death due to ventricular fibrillation. Mind you, he permitted a faulty memory to confuse a dysrhythmia with coronary thrombosis. If this internist, or a myriad like him in similar instances, can propose that a chronic exposure to a minute amount or even to excessive amounts of the solvents, which were not present in this case, can produce coronary heart disease, then a new clinical entity in industrial medicine is being established without the consent of those authorities who know otherwise.

If such a disease can be accepted as resulting from an exposure to carbon tetrachloride without any proof of fact, then there is no reason why one might not contend that diabetes or arthritis or other communal disease can result from the same substance. Or, to further confound the medical profession, if one can conclude that the inhalation of such a substance can cause coronary sclerosis, then the now accepted pathology of this disease might as well be discarded.

Physicians in or out of an industrial practice, especially those out of this practice, who toy with the occasional case only, must remember that in industrial medicine, just as in general medicine, known recognized clinical entities are developed through a process of repeated observations, clinical investigations, and laboratory support. The careless, thoughtless, unfounded opinion is a damnable scourge to the true significance of the occupational diseases.

In closing, you are aware by this time that this paper has been no scientific exposé, nor was it so intended. There are numerous sources for the novitiate in this type of practice to ascertain the scientific data necessary for his knowledge. I fear, however, that we have reached a stage in medicine where most of us are too dependent upon formulae and figures, to the detriment of practical observation. I also feel that in a general practice we are limited to opportunities for constructive observation. Industrial medicine, on the other hand, offers an opportunity to utilize one's own senses without in many instances, laboratory equipment.

Dare I even hope that I have stimulated even a very few of you to accept the opportunities industrial medicine offers for practical observation and, like Semmelweiss, by such God-given means make an undying contribution to medicine?

Pre-employment Gynecological Considerations

During the pre-employment physical examination, a knowledge of the previous health of the prospective employee is basic in evaluating the ability of that individual to do safely the job to which she has been assigned. It is of extreme importance to know whether there have been disabilities arising from dysmenorrhea, pelvic pain, repeated abortions, excessive menstrual flow or inter-menstrual bleeding, etc. It is just as basic that a pelvic examination should follow in the completion of such an evaluation.

X-ray of the chest, visual acuity tests, blood pressure readings, urine examinations and serological tests have become standard procedures in the pre-employment examination. Knowledge of any pathological state of the employee's pelvic organs is just as significant.

The importance of such knowledge becomes apparent when we study the trend of legislation relative to compensable occupational disease. Today, many of our state laws make little, if any, distinction between the liability of the employer in cases of disability arising directly out of employment, or such liability being the result of an aggravation of a pre-existing pathological state.

The prospective employee should be informed that the pre-employment examination is for the purpose of safe placement at work. It has been our experience that she readily accepts any examination that serves to protect her against disability or the aggravation of an already existing disease. Knowledge of past gynecological or obstetrical pathology, along with pelvic examination, is a fundamental inclusion in adequate health maintenance programs for the industrially employed female worker.—Max R. Burnell, M.D., Flint, Mich.; Industrial Medicine, Vol. 13, No. 3, March, 1944.

Organized Air Evacuation Service of the Army Air Forces

RICHARD L. MEILING, M.D.

JUST one year ago this week the first air evacuation squadron of the Army Air Forces departed from Bowman Field, Kentucky, for the North African front. In the succeeding twelve months a similar air evacuation squadron has arrived in each of the combat zones where the American armed forces have engaged the enemy. Other air evacuation squadrons are now operating along the greater portion of the Air Transport Command's global routes. Aboard American planes the personnel of these air evacuation squadrons provide the medical care for patients. The patients are the casualties of our own armed forces, of our allies, and, in many cases, prisoners of war, but patients nonetheless.

The records of the Army Air Forces show that more than 175,000 casualties (sick, wounded, and injured) have been transported aboard American airplanes since Pearl Harbor. These casualties have included, with few exceptions, every type of injury, wound, or disease described in medical literature. The planes carrying these patients have flown in every type of weather, climatic and geographical condition known to global air travel . . . from the arctic to the tropics, across deserts, mountains and oceans. Our air-minded generation of today accepts air travel as a safe means of transportation, and the airplane provides the most rapid and most comfortable facility available for transporting patients.

THE HISTORY

Before summarizing the development and operation of the organized air evacuation service of the Army Air Forces, let us consider the chronological history of the use of the airplane as a means of transporting patients.

Our French allies during World War I were the first to adapt an airplane to such use. Dr. Chassning prevailed upon the French Chamber of Deputies in 1917 for the funds to build an airplane to accommodate one patient. It is said that he was rebuffed on the floor of that august legislative body with such criticisms as, "Are there not enough dead in France today without killing the poor wounded in airplanes?" Dr. Chassning was apparently of a persevering character, for, in September, 1917, at Villa Coublay the records show that the good doctor served as the first patient to be transported by air. Later this same plane was used on the front at Amiens and the Marne.

Presented December 20, 1943, at the monthly meeting of the Medical Department of the District of Columbia, Walter Reed Hospital, Washington, D. C.

The Author

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The cornerstone of our present Army Air Forces Air Evacuation Service was laid at Gerstner Field, Louisiana, in February, 1918. Here Capt. William C. Ocker of the Air Corps and Maj. Wilson E. Driver of the Medical Corps jointly designed and operated the first American plane (a Jenny bi-plane Nr. 3131) used to transport patients. It is this same warm cooperation between flying personnel and medical personnel of the Army Air Forces that has made air evacuation successful on such a large scale today.

Progressive medical officers have, in the years prior to the present war, repeatedly recommended the adaptation of air evacuation to the strategical and tactical planning of our military organization.

However, as late as December 7, 1941, the use of air evacuation on a large scale to support a major military task force operation was still considered by many military authorities in our country to be dangerous, impracticable, medically unsound, and militarily impossible.

Our German enemy had demonstrated, however, the practicability of air evacuation on a large scale during the Spanish Civil War of 1936-1938, flying German casualties from Spain to the University and Military Hospitals of Germany. Full use of air evacuation during the Polish, Norwegian, Lowland, French, Balkan, Russian, and Libyan campaigns was made by the Germans. This permitted utilization of the hospitals within Germany for definitive treatment, convalescence and rehabilitation of the military casualties.

It was in the Spring of 1942 that the War Department made the Commanding General, Army Air Forces (Gen. H. H. Arnold) responsible for the development, planning and operation of air evacuation for the three components of the newly-reorganized Army of the United States. General Arnold thereupon delegated the Air Surgeon (Gen. David N. W. Grant) to supervise air evacuation and coordinate its development and operation with the Air Staff, other War Department and Governmental Agencies, and the Air Forces of our Allies.

The transportation of military casualites resolves itself into two essential problems. The

first is the military logistical problem and second is the medical problem. Air evacuation must, of necessity, present a sound solution to both.

THE PROBLEMS INVOLVED

The military logistical problem is a very real one. Every commanding general is faced with difficulties involving the evacuation of the non-effectives during offensive action. Motor ambulances, hospital trains and hospital ships, protected as they are by Red Cross insignia, are restricted in use to the transportation of patients and medical supplies. This single-purpose type of special equipment requires a considerable amount of fuel, personnel, road space, railroad siding and dock facilities which well may be used, at least in part, for the offensive action.

Therefore, Gen. Grant recommended the utilization of available cargo and transport planes rather than procurement of specially designed airplanes marked with the Red Cross insignia for air evacuation. The same planes which fly the airborne troops, paratroopers, equipment, supplies, fuel, ammunition and material to the forward areas are readily converted in a few minutes to carry patients on their return flight to the rear areas. Air protection must be provided to all transport aircraft in combat areas, whether they be on an "offensive mission or a mercy mission".

The second phase of the military logistical problem involves the movement of non-effectives from the theater of operations to the homeland. It has been stated that eight and one-half tons of supplies are required during the first thirty days to support each military individual sent to the theater of operations and that an additional one and one-half tons are required every thirty days thereafter. The number of large (general) hospitals, medical personnel, and supplies for patients required in the combat area may be materially reduced by utilizing the available space aboard the Air Transport Command planes to return patients to the United States.

But, lest my critics consider me too enthusiastic about air evacuation of patients, let me assure you that I do not visualize the total replacement of all surface facilities by the use of air evacuation. The close coordination of both surface and air facilities will assure, however, the most rapid and most comfortable transportation of the maximum number of patients with the minimum interference with the offensive mission of the military force.

The Army Air Forces utilizes, therefore, the cargo and transport planes of the Troop Carrier units within the theater of operations and those of the Air Transport Command between the theaters of operations and the United States as the "carriers" for the organized air evacuation service. (I might add that it is the rule rather than the exception that patients and their medical attendants comprise only one part of the air-load. Patients, personnel, cargo, mail, and equipment are often transported aboard the same plane.)

THE TYPE OF PATIENTS

The second problem of transporting patients is the medical problem. During the past twenty years much thought has been given to the theories concerning the selection of the type of patient that might be transported by air.

During 1942 the medical personnel of the tactical air squadrons, operating on the particular air base involved, were used to care for patients being flown to fixed medical installations. Experience, however, has shown that the solution of the medical problem is to provide specially trained medical personnel to care for the patients while in flight.

To provide the trained medical personnel, the Air Evacuation Squadrons were developed and the Army Air Forces School of Air Evacuation was established. Today, at the School of Air Evacuation flight surgeons, flight nurses and selected medical department enlisted men of the Army Air Forces are trained to provide the necessary medical care to patients while in flight.

Our Allies have shown great enthusiasm for the work of this school. Recently two doctors and seven nurses of the Royal Canadian Air Force spent eight weeks as students there. The British, Australian, Free French, and Greek air officers have been impressed by the policies of the Army Air Forces air evacuation service as taught at this school and have presented them to their respective governments.

PERSONNEL UTILIZED

The Medical Air Evacuation Transport Squadron is composed of five flight surgeons, one Medical Administrative Corps officer, twenty-five flight nurses and sixty-one enlisted men. Each squadron is organized into a headquarters section and four flights. Each flight is commanded by a flight surgeon and is composed of six evacuation teams. An evacuation team, consisting of one flight nurse and one staff sergeant (surgical technician), is assigned to each plane to provide medical care for the patients while en route.

Each evacuation team carries a "chest, airplane ambulance" in which the necessary medical equipment, drugs, blood plasma, etc., are packed. The automatic flow of medical supplies, the standard operating procedure for ground operations, of necessity, has been successfully modified in each theater of operations to meet the contingencies of large scale air evacuation.

During 1942, the Army Air Forces provided air evacuation service in the Burma and Java withdrawals. In August, 1942, the Fifth USAF introduced air evacuation to the Australian and New Guinea theaters, where it is today an ac-

cepted military procedure. On September 3, 1942, the Marine Corps began air evacuation from Guadalcanal to be joined that same month by both Navy Air Force and Army Air Force units. In the succeeding fifteen months this combined operation, known as SCAT has evacuated approximately 25,000 patients.

During eleven of the fifteen months, medical care has been provided to SCAT operations by an Air Evacuation Squadron. You will recall how, at the October meeting of this group, Colonel Sams, former surgeon of the Middle East theater, stated that air evacuation was the solution to the medical problem in that theater, which involved an area some 3,000 miles in length, and that the Ninth USAF assisted during the Libyan campaign in evacuation of casualties of the Eighth British Army.

Since early 1942, the Eleventh USAF in Alaska has provided a most effective air evacuation service throughout this theater. In China and India our forces are dependent on air evacuation due to the limited surface transportation facilities. In the recent Gilbert Island action in the Central Pacific area, patients aboard planes of the Seventh USAF began to arrive in Hawaii on November 23 (three days following the initial landing at Tarawa and Makin).

During the North African, Sicilian, and Italian campaign more than 58,000 patients have been transported aboard the planes of the Twelfth USAF. I might add that in one day, recently, this Air Force transported more than 600 patients. This was accomplished in a combat area and is indeed a tribute to the skill of the pilots, ground crews, and medical personnel with the Twelfth Air Force.

On the global routes of the Air Transport Command during the month of November, 1943, more than 1,300 patients were transported by air . . . of this number, approximately 50 per cent were flown directly to the United States. These patients originated from American bases located all over the world (India, China, Australia, Africa, Persia) many being in areas inaccessible to surface craft. By the utilization of the returning Air Transport Command planes, these patients were returned in a matter of hours (58 hours from China to Washington, D. C.) to the superior medical facilities of this country at no additional cost in fuel or equipment. Nor did they require extensive medical facilities en route, a flight nurse and surgical technician being their sole attendants. Consider, if you will, the morale of these patients, many of whom had spent one or two months aboard ship traveling to their far flung posts of duty.

The medical personnel, serving our armed forces today, should be cognizant of the fact that patients who may not be considered favorably for a long, arduous trip in a surface craft may be transported by air today without undue hardship or embarrassment. In a matter of hours the patients can be flown a distance which by surface craft might take weeks or months.

AN ACCEPTED PROCEDURE

During this past year organized air evacuation service has progressed from a plan to an accepted military procedure. In the coming year each cargo and transport plane will be equipped on the factory production lines with litter supports. The development and field tests of the helicopter have been most encouraging and it is anticipated that a cargo type helicopter will be available in the near future for service in areas where air fields are lacking.

The experience gained in transporting patients by air must be translated into the medical plans of future military operations, the demobilization period and the development of our post-war bases. The medical information concerning the air travel of this large group of patients will be of value to every medical officer, yes, every member of the American medical profession, for the passengers of the global air routes of tomorrow will be our peace-time patients. It is, therefore, our duty to these patients to put aside our provincial and localized medical thinking and base our future medical training on the problems of global medicine, with full consideration to the preventive, diagnostic, and clinical aspects thereof.

Foulger System of Control

On the first examination of the individual a brief environmental survey is taken, including diet, amount of sleep and commuting distance (which in many cases amounts to 90 miles daily). The new operator is also questioned on previous illnesses, particularly anemia, gall-bladder and kidney disease, gastric ulcers and rheumatic fever.

At the end of the five-minute rest period, the blood pressure is taken on both arms, noting the fourth and fifth phases of diastolic pressure, and the pulse rate determined. Abnormal blood pressures are checked by the second member of the team of two technicians. Individuals showing significant abnormalities of hypo- or hypertension are sent to the hospital to be seen by the industrial medical officer. After the blood pressure reading, a complete blood count is taken, and urine specimen obtained.—Major E. W. Probst, M.C., and L. D. Lewis, B.S., Picatinny Arsenal, Dover, N. J.; Industrial Medicine, Vol. 13, No. 1, January, 1944.

Parathyroid Adenoma—Report of Unusual Case

DOUGLAS GOLDMAN, M.D., and ALBERT SAPADIN, M.D.

SINCE Mandl's first report of clinically recognized and successfully operated hypersecreting parathyroid adenoma in 1927 the clinical symptoms of this disease have become well recognized. Numerous cases of generalized osteitis fibrosa cystica and of renal lithiasis caused by hypersecreting parathyroid adenomata have been described by Du Bois, Albright, Aub, Barr and others.

The present case is believed of importance because it represents an instance of severe, apparently relatively acute hypercalcemia caused by an hypersecreting parathyroid adenoma, with no evidence whatever of bone involvement or kidney stones. Examination of the literature shows no similar case previously reported.*

CASE REPORT

Mrs. F. L., housewife. Previous hospital admissions:

8-9-22—8-20-22. Pregnancy in labor.
11-3-24—11-12-24. Pregnancy in labor.
9-21-25—9-29-25. Endometritis and Submucous Fibroid, Rx: D & C.
10-7-25—12-24-25. Cystic ovary and retroverted uterus. Rx: Left salpingo-oophorectomy, right partial salpingectomy, appendectomy, shortening of round ligaments.
1929. Cholecystotomy with removal of common duct stone at another hospital.
3-16-33—4-18-33. Cholecystitis with cholelithiasis: Rx Cholecystectomy—exploration and drainage of common duct.
7-13-33—7-18-33. Acute cholangitis with possible stone in common duct.
8-6-33—8-13-33. Stone in common duct—acute cholangitis.
6-13-41—6-22-41. Varicose veins. Rx: Bilateral Saphenous ligation.
Present admission—7-14-41.

Chief complaint: Nausea, vomiting, pain in abdomen, weakness, and constipation.

Present illness: Since cholecystectomy in 1933, the patient had frequent episodes of biliary colic with mild jaundice of short duration; anorexia, nausea, vomiting, and constipation. The patient was on a rather limited low fat diet. She took magnesium sulfate, oz. 1 every morning for constipation.

Three weeks before admission she developed sharp, "sticking", right upper quadrant pains, which radiated around the right flank to the back and shoulder blades. At the same time she developed persistent nausea and vomiting. She lost 18 pounds in the interval from the onset of her illness to her admission. When seen in Clinic on 7-14-41 slight icterus of the sclerae was noted and she was sent into the hospital.

*The case of Mason and Gauther which was recognized postmortem after a single high blood calcium shortly before death was probably quite similar.

From the Medical Service, Jewish Hospital, Cincinnati, Ohio.

On admission: T. 98.4—P. 80—R. 22. Examination revealed an obese 39 year old white female not acutely ill. The skin and sclerae had a definite sub-icteric tint although no jaundice was noted. There was questionable fullness to the left lobe of the thyroid gland. The chest was clear to P. and A. The heart tones were of good quality and of regular rhythm. A2 was greater than P2 and tympanitic. Blood pressure 170/90. The abdominal muscles were markedly relaxed and there was tenderness in the epigastrium and right upper quadrant. The liver was palpable 3 finger-breadths below the costal margin in the right mid-clavicular line. Peristalsis seemed decreased. Two scars of previous operations were noted on the abdomen. The deep reflexes were either absent or hypoactive. Muscle tone of the extremities was noticeably decreased.

Impression at this time: Stone in the common duct.

Laboratory findings: Urine: Straw colored; sp. gravity—1.010; faint trace of albumin; otherwise negative. R.B.C. 3,760,000; W.B.C. 6,150; Hb. 70 per cent (Dare); Polys 58 per cent; Lym. 39 per cent; Mon. 1 per cent; Eos. 2 per cent. Blood N.P.N. 25.8 mgm.; blood cholesterol 303 mgm.; blood chlorides 500 mgm.; Vandenbergh Direct—negative, indirect—trace; Icteric Index—8. B.M.R. plus 3, and plus 6.

The patient was given a high carbohydrate liquid diet supplemented with several intravenous injections of 10 per cent glucose in saline. She took fluids moderately well but her anorexia increased, she became more listless, and drowsiness became more prominent daily. She had no fever at first but with the onset of drowsiness temperature rose to 100 to 101 degrees.

The patient was not responding to therapy obviously, but no jaundice or other evidence of increasing biliary tract disease appeared. History of intake of magnesium sulfate over a long period of time suggested that some disorder of calcium metabolism might be present. This was admittedly hyperbolic clinical logic. Determination of the blood calcium and phosphorus on the eighth hospital day revealed the presence of marked hypercalcemia and hypophosphatemia (see Table 1). X-rays showed no evidence of osteomalcia or renal lithiasis. The urinary calcium was increased. Blood Phosphatase was normal, 3.2 U. (King and Armstrong method).

Recorded impression: Hypersecreting parathyroid adenoma.

On the ninth hospital day sodium phosphate therapy was started in an effort to reduce the hypercalcemia and improve the patient's condition preparatory to operation. The nausea and vomiting became so severe, however, that a Wangensteen apparatus had to be set up in order to give relief. Despite the fact that daily checks of the blood CO_2 combining power were being made she developed alkalosis (bl. CO_2 combining power—98 volumes per cent on the eleventh hospital day. This was picked up by routine check—patient showed no signs or symptoms of alkalosis. The sodium phosphate medication was

TABLE 1

Date	Bl. Ca.	Bl. P.	Remarks
7-21-41	17.0	2.2	
7-22-41	18.0	2.2	Na Phosphate started
7-23-41	16.8	3.0	Alkalosis—7-24-41
7-25-41	17.0	2.5	(Operation) Ca. lactate; 100 U. Pth. Ext. 7-26
7-27-41	15.0	2.3	100 U. Pth. Ext.
7-28-41	14.6	3.2	Phosphatase 3.2 U, Chol. 255 mgms, Serum Proteins 7.1, N.P.N. 31.
7-29-41	14.4	1.8	
7-30-41	15.0	2.1	
7-31-41	12.0	2.3	
8- 1-41	11.4	2.4	
8- 4-41	11.0	4.1	
8- 7-41	11.0	4.2	
9- 2-41	10.8	4.0	

discontinued. The carbon dioxide combining power of the blood fell satisfactorily after intravenous glucose and saline and transfusion of 500 cc. citrated blood.

With reduction of the alkalosis the patient seemed somewhat improved, although the blood calcium level was almost as high as before phosphate therapy. Her nausea and drowsiness decreased, the vomiting diminished and she was able to take fluids and toast. The temperature returned almost to normal. Following improvement of her condition operation was performed on the 12th hospital day.

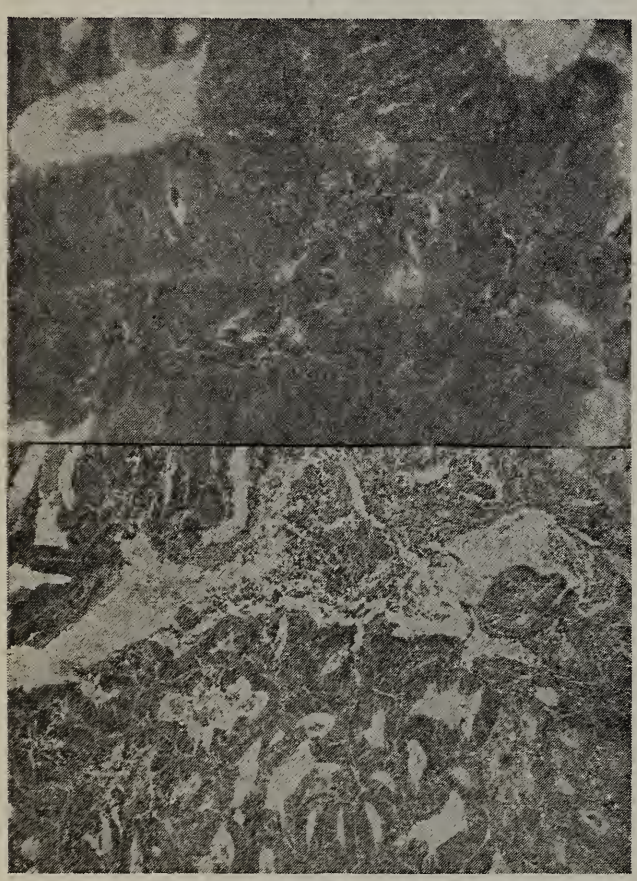


FIGURE 1

Photomicrographs of adenoma with low and high power dry objectives.

At operation performed by Drs. Leon Goldberg and J. L. Ransohoff an adenoma of the parathyroid gland was found lying behind the lower pole of the left lobe of the thyroid and excised. It was 2 cm. in diameter and encapsulated (Fig. 1). Further search was made of all the other parathyroid bodies for other adenomata, but none was found. The patient was returned to the ward in good condition.

Her convalescence was rapid and uneventful. Since it was desired to reduce the blood calcium slowly to avoid post-operative tetany which is common in such patients she was given 100 units of parathyroid extract prophylactically on the first and second postoperative days; oral calcium lactate therapy was started on the first postoperative day. The patient could take fluids well four hours after the operation; soft foods on the first postoperative day; and was up in a wheel-chair on sixth postoperative day. She stated that she felt better after the operation than she had for years. Calcium and phosphorus values of the blood (Table 1) gradually returned to normal. Six months after discharge from the hospital the calcium and phosphorus values were still normal and the patient had gained over 30 pounds. Her constipation, abdominal pain, nausea and vomiting, anorexia, and weakness have never recurred.

DISCUSSION

This case presented an unusually urgent clinical problem. The obvious cause of anorexia and intractable vomiting was the previously recognized and surgically treated disease of the biliary tract. Clinical suspicion of the possibility of some other disorder causing the symptoms was based chiefly on the failure of jaundice to materialize and the "long-shot" hunch that protracted use of $MgSO_4$ could disturb the calcium metabolism. More cases as well as laboratory experiment will be necessary to determine whether this was just a fortuitously fortunate idea or true clinical inspiration. The laboratory findings were pathognomonic. Persistent hypercalcemia and hypophosphatemia allowed no other diagnosis. With intensifying clinical symptoms responding to no other measure surgery in this case must be considered to have been a conservative and life saving measure in spite of the rareness of the disease and a diagnosis based chiefly on laboratory evidence.

The lack of bone involvement which is usually

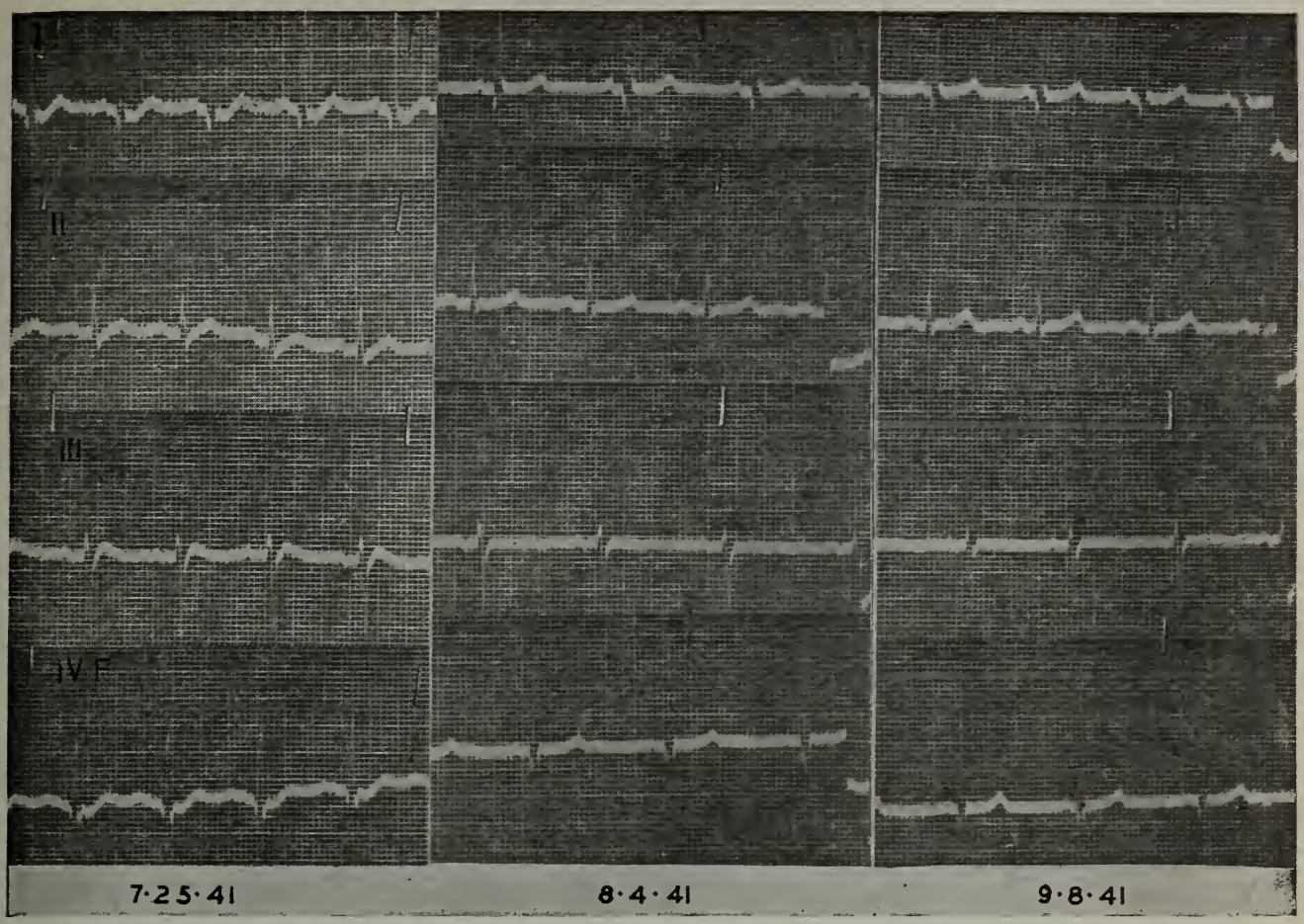


FIGURE 2

Electrocardiograms before, immediately after and approximately 6 weeks after operation. Changes in the T waves and S-T intervals from hypercalcemia are evident and disappear following return to normal of the blood calcium.

the most conspicuous change in most of these cases must be attributed to the relatively early phase of the hypercalcemia. The normal blood phosphatase can be considered to reflect the normality of the bones. The failure of renal calculi to develop in spite of increased urinary excretion of calcium must also be considered evidence of short duration of hypercalcemia. In the presence of such severe and almost hyperacute hypercalcemia it may well be thought doubtful whether this patient could have lived to show evidence of the more chronic stages of the disease.

Electrocardiograms showed interesting changes when hypercalcemia was relieved. The first tracing shows the changes characteristic of hypercalcemia, later tracings were more nearly normal (Fig. 2).

Purely clinical diagnosis in such cases is impossible and this case may be cited as an example of the potentialities of modern medicine when clinical and laboratory evidence is combined to produce results not inherent in the restricted use of either one.

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Annual Examination

Frequently an annual examination gives information regarding either a funtional or organic condition which will be of value in proper work adjustment. It is our belief that the exposure to a positive health program over a period of years is of some public health and medical value. The results of annual examinations are tangible as well as theoretical.—H. H. Fellows, M.D., New York, N.Y.; Industrial Medicine, Vol. 13, No. 1, Jan. 1944.

Hypertension

Definite hypertension rarely develops between annual examinations. As a rule, there is a gradual increase from year to year, or the blood pressure may be elevated intermittently before hypertension is established. The recognition of either method of onset brings a case under observation and supervision.—H. H. Fellows, M.D., New York, N.Y.; Industrial Medicine, Vol. 13, No. 1, Jan. 1944.

Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

INTRAPLEURAL PNEUMONOLYSIS

IT seems generally agreed that at least half the cases of pulmonary tuberculosis require some form of collapse treatment, either reversible or irreversible. Thoracoplasty is the best surgical example of the latter, while the oldest technique devised—pneumothorax—is a good representative of temporary, reversible collapse of the lung.

The chest specialist is the one to select either method after he has evaluated the patient's condition and the stage of his tuberculosis. The mistaken belief that "time heals everything" must give way to acknowledgment that this disease demands immediate consideration invariably and active methods of treatment whenever indicated. In this race against time, presence of a cavity calls for measures to obliterate it before delay invites a hemorrhage or spread results in a hopeless condition.

Pneumothorax remains the first choice, but is successful in only about half the cases in which it is initially tried. Lack of success may be attributed to adherence of the two pleural surfaces so that collapse of the cavity is impossible or incomplete. Delay in the institution of pneumothorax may allow the parenchymal inflammation to progress and involve the pleurae until adhesions form and so defeat later attempts at what should have been a simple collapse procedure.

Formerly, a risky method attempted to stretch or break such adhesions by forcing air into the pleural cavity under positive pressures. Serious complications developed if the adhesion, breaking off near the lung, tore the latter so that a tuberculous or mixed infection empyema resulted. Serious hemorrhage might follow rupture of a sizeable vessel incorporated in the adhesion. Precious time was often wasted while the hoped-for stretching of the adhesion was awaited. Meanwhile the still unaffected cavity might supply baccilli to cause other cavities elsewhere.

Intrapleural pneumonolysis was designed to transform, where feasible, a poor penumothorax result into a satisfactory effective collapse. Under local procaine infiltration anesthesia, a special cannula is introduced between the ribs into the pleural space, transmitting a visual instrument not unlike a cystoscope. Through this the operator views the interior and by means of a cautery inserted through a second cannula in another interspace severs the adhesions under direct vision.

Adhesions vary in size and shape and may be multiple. They range from "fiddle string" to short, thick and cylindrical, or may resemble accordian pleated sheets that radiate in all directions and run all the way from paper-thinness up to bands one or several centimeters in diameter. In using the cautery it is necessary to remember that thicker adhesions may contain lung tissue or large blood vessels and that they may be attached firmly to the aorta, subclavian artery or vital mediastinal structures. Great skill is required to avoid disasters similar to those already listed above as chargeable to stretching and rupture of adhesions.

A skilled operator will sever an adhesion as near its parietel extremity as possible, thus protecting the lung while exercising due caution as regards the intercostal structures as well, especially if actual dissection in the latter area proves necessary. In competent hands, backed by adequate experience and judgement when and when not to cut, the operation is a minimal one as regards the patient's discomfort. In less experienced hands, however, it can present dangers exceeding those of almost any other major intrathoracic surgical procedure.

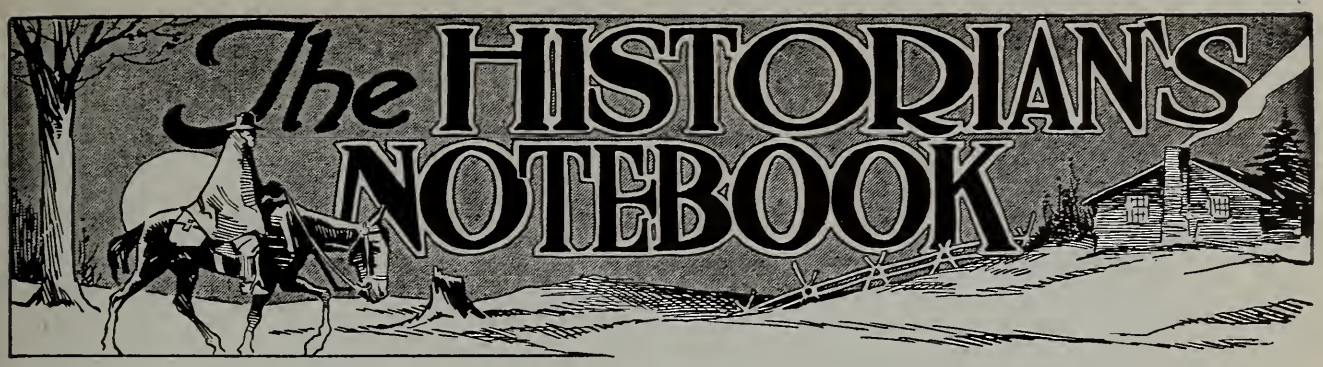
When a pneumothorax is started and adhesions can be seen to interfere with collapse, provided the space is large enough for the surgeon to manipulate his instruments, there is no reason for delay. Besides the well-known hazards of an open cavity, the longer one waits the thicker grows the pleura covering the bands and the greater the difficulty of cutting them.

Very large adhesions may have to be severed partially at one sitting and finished in stages after waiting periods of three or four weeks have intervened. Adhesions too widespread to submit to this method call for abandonment of the unsuccessful pneumothorax and the selection at once of a collapse procedure other than pneumonolysis.

Remember the time factor and begin active pneumothorax treatment immediately upon an individual who has a cavity. Don't wait to see what happens to the case with prolonged bed rest. Too often the realization will be accompanied by disappointment and chagrin.

In about half the cases a pneumothorax will be complicated by adhesions.

Don't attempt to stretch adhesions by means of a positive pressure pneumothorax.—Intrapleural Pneumonolysis, Lt. Comdr. James E. Dailey, M. C., U.S.N.R., Diseases of the Chest, Nov.-Dec., 1943. (Reviewed and passed by The Bureau of Medicine and Surgery, U. S. Navy.)



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

The Clyster In Early Medical Practice

PHILIP D. JORDAN, PH.D.

WHEN the frontier physician, practicing in pioneer Ohio during the early days of nineteenth-century medicine, ordered a clyster for a frontiersman, he was prescribing a course of treatment known to men of medicine of classical times. Egyptians, Greeks, and Arabs forced liquid preparations through the anus in order to evacuate the bowels and clean the large intestines. But it was the French who perfected the *clysoir*, an apparatus for administering enemata which consisted of a long, funnel-shaped tube of elastic gum fitted with a pipe at the apex, and who also developed the *clysopompe*, an instrument similar to the *clysoir* but with a syringe attached.[1]

So important, indeed, had the use of the enema become in 1854 that the tenth edition of the *United States Dispensatory* felt obliged to comment in detail upon enemata and the use of the clyster.[2] Yet the frontier doctor had used the clyster or glyster since the time of the American Revolution. Among the instruments packed for the Lewis and Clark expedition was a clyster syringe valued at $2.75.[3]

The Author

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UNIVERSAL USE

Enemata seemed to be one point, at least, upon which physicians of the regular school and of the botanic schools could agree. Even the hydropathists, who commonly opposed all techniques endorsed by allopathists, homeopathists, and eclectics, approved the clyster of slightly tepid water or of cool or cold water and informed their patients that the best instrument was a pump syringe, costing from three to five dollars, but saying that "very good" metal syringes could be procured for as little as fifty cents.[4] In 1854, a hydropathic physician devised a pocket syringe which, it was said, enabled "the individual to inject any desirable quantity of fluid without interruption, and is preeminently superior as a 'Self Syringe' inasmuch as the piston may be worked with one hand, thereby leaving the other hand free to follow the terminal tube."[5] In both England and America materia medica texts devoted space to formulae for clysters.[6]

In England, during the reign of James I, the use of an alleged poisonous clyster which resulted in the death of Sir Thomas Overbury, set royal tongues to wagging and involved an apothecary, Paul de Lobell, and his assistant.[7] An early nineteenth-century English text recommended injections containing thin gruel, warm milk or water, hog's lard, castor oil, starch, and laudanum.[8] In 1804, an Irish author advocated the "common" clyster in the treatment of fevers.[9] It was relied upon for the treatment of both animals and men.[10]

IN THE BACKWOODS

The clyster was an admirable technique in a backwoods community where prepared medications were scarce. In addition, the enema could be administered with a fair degree of ease by members of the patient's family. "Language almost fails to express the great value of this innocent and powerful remedy," wrote the author of one of the leading domestic medicine volumes of his day. "There are many persons, both men and women, who are constitutionally subject to costiveness: by which I mean, being bound in their bowels so that they can not have regular stools. This costiveness arises from a variety of causes; such as diseased liver, indigestion, torpor

of the bowels, and from improper food being taken into the stomach and bowels, and always produce spasms or colic pains; for remember this, that whenever your stomach and bowels are disordered, you will become costive, your head will be confused and otherwise distressed, your spirits will become low and dejected, and the whole train of hypochondriacal feelings and sensations will haunt you. All these symptoms can easily be relieved by a simple clyster, made of equal quantities of milk and water, and thrown up the bowels; for by this your bowels will be relieved of their load, which always produces irritation, and your mind and feelings soon experience an agreeable change."[11]

DR. GUNN

Gunn then advised settlers of the Western Country how to use the clyster. His discussion is one of the better descriptions not only of the proper method, but also of the type of equipment used on the frontier. "The common method of using the old glyster pipe", he wrote, "is as follows: You are to take a beef or hog's bladder, which has been blown up and suffered to get dry; and after inserting and fastening a short hollow reed or quill in it, cut off at both ends of the barrel, you are to put the glyster itself into the bladder. The end of the reed or quill, or of the glyster pipe of the shops, if you use one, is to be covered with some oil or lard, and gently put up the fundament about an inch, by an assistant, and the sides of the bladder squeezed together gradually, so as to throw its contents as far as possible up the bowels.

"The new invention consists of a pewter syringe or pipe, called a *self pipe;* the meaning of which is, a pipe that can be used without an assistant. It is so constructed as to be used by yourself, or by an assistant, if you are so weak as to require one. The pewter syringe, holds nearly a quart, and by a screw a long pipe is connected to the syringe, which holds the glyster itself. All that is required, is to put the small tube into the fundament, and gradually to bare on the handle of the syringe, which, as you bare down steadily, throws the glyster up the bowels. The force with which the glyster is thrown up the bowels, depends on the pressure of the handle of the pipe. You are to recollect that force, unless it be very gentle and steady, is never to be used; all you have to do, is to press gradually on the handle of the syringe, by which you will feel the distension of the bowels as the glyster is thrown up."[12]

TECHNIQUE

The common method of administering a clyster in the Western Country was to lay the patient on the edge of the bed with the buttocks a little over the side and the knees drawn up near the belly. Then the pipe was introduced with one hand while the other was placed near the thighs, a little backwards near the backbone so as to lend support. Once the pipe was introduced, the bladder was gently squeezed, thus forcing the liquid into the large intestines. The patient was urged to retain the preparation as long as possible. The amount of liquid varied from a quart to two gallons, although Mattson felt that an ounce was sufficient for an infant a year old; two ounces for a child five years old, and three ounces for a youth 12 years old.[13] A physician in Logan County, however, testified that he gave a four-year-old boy, afflicted with worms, "about 100 grs. calomel, 75 of scammony, 75 of jalop, and 2 pints of decoction of spigelia and senna, besides a large quantity of oil and epsom salts by the mouth, and an incredible quantity of senna, salts, and tartarized anitomy by injections."[14]

Injections were prepared, as might be expected, with a variety of ingredients. The common soapsuds enema was in use as were clysters made with a tablespoonful of cacined charcoal, a half pint of boiling water, or flax seed or slippery elm tea, a teaspoonful of salt and two teaspoonfuls of molasses. Still another injection "of great value" contained a pint of sweet milk, a pint of mucilage of slippery elm, a gill of olive oil, half a pint of molasses, and a drachm of salaeratus.[15] Sometimes, especially if there was a great pain in the lower intestines, a drachm of laudanum was added. Kost, an Ohio botanic physician practicing at Mt. Vernon, advocated as a "relaxant" injection of a pint of strong tea of thoroughwort to which were added a heaping teaspoon of green lovelia and an equal amount of slippery elm powder. His "stimulating" injection was prepared by making a strong tea of pennyroyal or peppermint and adding half a teaspoonful of tincture of myrrh. This was said to be "particularly serviceable in all cases of constipation and torpidity of the bowels, and in cases where mortification of the intestines is apprehended."[16]

THE BOTANICS

Mattson, one of the better-known members of the botanic school, recommended an infusion of catnip, pennyroyal, fleabane, ginger, black pepper, summer savory, or any of the stimulating herbs,[17] and Mills approved the use of a tablespoonful of fresh lard, or of butter and molasses to which were added a teaspoonful of salt and a pint of hot water.[18] Samuel Thomson, founder of the system which bears his name, said that the common preparation for an injection or Clyster, is to take a tea-cupful of strong tea made of No. 3, strain it off when hot, and add a tea-spoonful of No. 2, and a tea-spoonful of No. 6; when cool enough to give, add a half tea-spoonful of No. 1, and the same quantity of nerve powder."[19] What Thomson was doing, of course, was making a clyster with practically all of the ingredients which he considered essential to his course of treatment.

As time went on and new drugs and preparations came upon the market, the frontier physician could choose for his clyster from a long list of approved injections. The tobacco clyster, for example, was recommended in cases of strangulated hernia and consisted of from half a pint to a pint of *Infusum Tabaci.* Sometimes the smoke of tobacco was thrown up the rectum.[20] Dr. F. J. Stratton, West Alexandria, Ohio, reported in detail the use of a clyster of tobacco smoke in the treatment of strangulated hernia. Before resorting to surgery, Stratton determined to try the effect of tobacco smoke thrown up the rectum. "For this purpose," he said, "a large sized gum-elastic catheter was obtained, and the open end inserted into the short stem of a common clay pipe. The connection was made air tight, by softening and pressing down the wax at the end of the catheter. The pipe was now filled with strong tobacco, ignited, and the catheter after being oiled passed up the rectum, the patient being on his elbows and knees. A strong muslin rag was now applied over the bowl of the pipe, and an individual directed to apply his mouth to the same, and blow at intervals as long as he could. In this way a large volume of smoke was thrown into the bowels. In three minutes the patient complained of nausea and a desire to evacuate his bowels."[21]

OFFICIAL CLYSTERS

The tenth edition of the *United States Pharmacopoeia* listed six clysters.[22] The Enema Aloes, intended as a formula for the use of aloes in cases of ascarides in the rectum, and of amenorrhoea attended with constipation, was made of two scruples of Aloes, fifteen grains of Carbonate of Potassa, and a half pint of decoction of barley. The Enema Assafoetidae, a carminative and antispasmodic as well as a laxative, was prepared with a drachm of prepared assafetida and half a pint of decoction of barley. The Enema Catharticum was mixed as follows: "Take of Olive Oil one ounce; Sulphate of Magnesia half an ounce; Sugar one ounce; Senna half an ounce; Boiling water 16 fluid ounces. Infuse the Senna for an hour in the Water; then dissolve the Salt and Sugar; add the Oil, and mix them by agitation."

For obstinate colic and constipation, the Enema Colocynthidis was employed. This was put up by taking a half a drachm of Extract of Colocynth, an ounce of soft soap, and a pint of water. "An admirable remedy in obstinate vomiting, strangury from blister, painful affections of the kidneys, bladder, and uterus, and in the tenesmus of dysentery" was the Enema Opii. This clyster took four fluid ounces of decoction of starch and thirty minims of Tincture of Opium.

Finally, the physician could use the Enema Terebinthinae which was made with a fluid ounce of Oil of Turpentine, the yolk of one egg, and nineteen fluid ounces of decoction of barley. Togno and Durand had listed four clysters in 1829,[23] and Paine, about 20 years later, noted ten, although he said, with much sense, that in the majority of cases warm water was sufficient.[24] Good favored the simple soap injection in preference to the more elaborate formulae.[25]

This tendency to favor the simple clyster, composed either of warm water or of soap, certainly was not unique to the three and fourth decades of the nineteenth century. As early as 1819, Parr strongly advocated them "and suggested" further that they should not be hot or cold, but should be warm enough to produce a pleasant sensation.[26] And there seems little doubt that most clysters administered on the fringe of settlement in the Western Country were of this nature and that they, as Thomson said, were perfectly safe in all cases.[27]

FOOTNOTES

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New Procedure Inaugurated To Assist Those Requiring Extra Rationed Food for Health Needs; Physician's Part Outlined; Tables and Forms To Be Used

BASED on authoritative recommendations of the National Research Council's Subcommittee on Medical Food Requirements, the Office of Price Administration initiated a new procedure, effective April 6, to be followed by persons who require extra amounts of rationed foods because of health needs.

Briefly, the new procedure is as follows:

1. Any person whose health requires that he have more foods than normally permitted, may apply, in person or by mail, for additional points to his local board, on O.P.A. Form R-315.

2. The application must be accompanied by a written statement from a physician, "licensed . . . to prescribe for human medication all internal drugs" certifying as to the diagnosis and the need for the supplementary rationing allowance; and a letter from the patient authorizing the physician to certify as to that diagnosis for the purpose of enabling the patient to obtain the extra food. **Mimeographed forms suggested by the National Research Council have been furnished to local rationing boards for the convenience of patients and physicians.** Text of the form follows:

Form to be Executed by Patient and Physician

To Ration Board No. ....., State of .....

I hereby request an extra allotment of such rationed foods as have been designated for the disease with which I am suffering, namely .....

..... (name of disease), and hereby authorize my attending physician, ...

..... (name of physician) to certify to the existence of such disease for the purpose of obtaining the designated foods.

..... (Signature)

..... (Address)

..... (Date)

..... (Number of Ration Book)

I hereby certify that I have examined .....

....., that my diagnosis of his (her) condition is .....,

and that he (she) has been under my care for .....months. I further certify that he (she) needs the amount of food specified for the disease for 2, 4, 6, 8, 10, 12 months.

(encircle appropriate number)

..... (Signature) ..... (Degree)

..... (Address)

..... (School of graduation)

..... (State and year of licensure)

..... (Date)

3. If the diagnosis is included in the list of illnesses recommended by the subcommittee as requiring increased amounts of rationed foods, the local rationing board is authorized to issue supplementary points. A list of these illnesses and the maximum number of points permitted will be found in the accompanying regulations and explanatory tables.

4. The period of certification for additional points in most instances will be for a maximum of 10 weeks. However, in cases of diabetes mellitus, active tuberculosis, chronic nephritis (nephrotic type), cirrhosis of the liver, and severe hepatitis, the certificate will be valid for one year. A statement certifying to the applicant's pregnancy need not be renewed during the term of pregnancy.

HOW OTHER CONDITIONS ARE HANDLED

5. Applications which do not come within the scope of the illnesses listed or which request more food than the amounts local rationing boards are authorized to issue, must be referred by the local board to the District O.P.A. Office for consideration. (There are four District Offices in Ohio, located in Cleveland, Columbus, Toledo and Cincinnati.)

6. If the District Office is unable to pass on such applications, it will submit them to the Regional Office in Cleveland. In reaching a decision, the Regional Office will be assisted by a Medical Advisory Committee.

TEXT OF REGULATIONS

For the information and guidance of physicians, *The Journal* is reproducing here the complete text of the new O.P.A. regulations pertaining to supplemental food rationing; a table showing the maximum weekly supplemental allowance of ration points; a reference table setting forth, in terms of weights and measures, the maximum weekly requirements for persons with illnesses, as recommended by the Subcommittee on Medical Food Requirements of the National Research Council; and the text of a form suggested for the use of consumers and physicians.

Para. 131 (a). Any consumer whose health requires that he have more foods covered by this order than he can get with his war ration book, may apply for additional points. The application must be made, on O.P.A. Form R-315, by the consumer himself or by someone acting for him, and may be made in person or by mail. The application can be made only to the Board for the place where the consumer lives. The application (on O.P.A. Form R-315) must contain a written statement signed by a person licensed by the laws of the state in which the certification

MAXIMUM WEEKLY SUPPLEMENTAL ALLOWANCE OF RATION POINTS, TO A CHILD OR ADULT; ALSO, MAXIMUM PERIOD OF PHYSICIAN'S CERTIFICATE

ILLNESS OR CONDITION	MEAT-FATS According to availability of poultry or fresh fish		PROCESSED FOODS*	EVAPORATED MILK If fluid Milk is not Available	Maximum Period of Certifications
	Available	Not Available			
Diabetes Mellitus	21	33	40	Child—8 Adult—4	1 year
Active Tuberculosis	13	23	7	Child—8 Adult—8	1 year
Chronic Nephritis (Nephrotic Type), Cirrhosis of the Liver, and Severe Hepatitis	28	41	None	None	1 year
Chronic Suppurative Diseases;** Severe Burns, and Gastro-intestinal Lesions (incl. cases following operations on the stomach, intestines or colon, for ulcers or cancer)	11	19	None	8	70 days
Pregnancy	None	None	None	8	Term of Pregnancy

* Processed Foods allowed on this chart represent the full requirements of such foods after the individual consumer ration is deducted. (No deduction was made for fresh foods.)

**This group includes empyema, osteomyelitis, extensive suppurative lesions of soft parts, subcutaneous tissues or muscles and those infections in which there is profuse pus formation.

is made to prescribe for human medication all internal drugs which may be prescribed within that state. However, if the consumer is pregnant, a Public Health Nurse employed by a federal, state or community public health agency, may sign such a statement instead. The statement must contain a specific diagnosis of the applicant's illness or condition, and must show why the applicant must have more foods covered by this order, the amounts and types he needs during the next ten weeks (or a shorter period if the illness is of shorter duration, and the probable duration of the illness.

Para. 132 (b). If the diagnosis is diabetes mellitis, active tuberculosis, chronic nephritis (nephrotic type), cirrhosis of the liver, severe hepatitis, chronic suppurative diseases (this group includes empyema of the chest cavity, osteomyelitis, extensive suppurative lesions of soft parts, subcutaneous tissues or muscles, and those infections in which there is profuse pus formation), severe burns, gastro-intestinal lesions (including post-operative cases involving operations on the stomach, intestines or colon for ulcers or cancer), or pregnancy, and if the Board finds that the applicant's health depends upon his getting more foods covered by this order, it shall issue to him one or more certificates for the number of points necessary to get additional foods covered by this order which he needs during the next ten weeks. If the diagnosis is any illness other than one of those specified in this paragraph, or if the applicant requests more foods covered by this order than the Board is authorized by the Washington Office to grant to him, the Board shall send the application to the District Office for decision. However, in emergency cases, if the Board finds that the applicant needs additional foods covered by this order, it may issue to him one or more certificates to enable him to get those additional foods during the next two weeks. If the District Office is unable to pass on the application, it shall send it to the Regional Office for decision, or take such other action as the Regional Office may authorize or direct.

Para. 132-A (c). An applicant who requires additional foods covered by this order for a period longer than the 10 weeks for which points are granted to him, may apply for additional points (in person or by mail) to the Board at the end of the ten-week period. However, the statement certifying the diagnosis of his illness need not be renewed more often than once a year, in cases of diabetes mellitis, active tuberculosis, chronic nephritis (nephrotic type), cirrhosis of the liver, and severe hepatitis. A statement certifying to the applicant's pregnancy need not be renewed during the term of the pregnancy. In cases where the statement certifying the diagnosis of the applicant's condition need not be renewed with each application for additional rations, his application for such additional rations shall be deemed to be a certification that he knows, or has reason to believe, the diagnosis of his condition remains the same as set forth in the written statement attached to his original application. If the applicant changes his residence before the time when he would have to renew the statement certifying the diagnosis of his illness, he may obtain the statement from the Board where it is filed and file it with the Board for the place where he will live.

In a circular to all field offices concerning the

MAXIMUM WEEKLY REQUIREMENTS FOR PERSONS WITH ILLNESSES

This table sets forth maximum needs of rationed plus non-rationed items in terms of weights and measures. Refer to the "Table for Granting Supplemental Allowances", to obtain maximum **allowances in points per week.** Applications for illnesses not listed will be referred by local board to district or regional offices.

ILLNESSES	TOTAL REQUIREMENTS FOR CHILDREN AND ADULTS			
	Meats (Rationed); Poultry and Fresh Fish	Butter, Fats, Edible Oils	Fresh Milk	Rationed Processed Foods (Fruits and Vegetables)
Diabetes Mellitus	4½ lbs.	1 lb. 7 ozs.	Children 7 qts. Adults 7 pts.	72 ozs.
Active Tuberculosis	4 lbs.	14 ozs.	7 qts.	56 ozs.
Chronic Nephritis (Nephrotic Type), Cirrhosis of the Liver, and Severe Hepatitis	7 lbs.	No Supplement	No Supplement	No Supplement
Chronic Suppurative Diseases. Severe Burns and Gastro-intestinal Lesions (including post-operative cases involving operations on the stomach, intestines or colon for ulcers or cancer)	4 lbs.	No Supplement	7 qts.	No Supplement

In most areas, consumers are able to obtain 25 per cent or more of their meat (animal protein) requirements in the form of fish and poultry which are excellent alternates. The "Table for Granting Supplemental Allowances" which converts this table into ration point allowances, takes this into account.

new regulations, the Office of Price Administration stated: "Extra amounts of rationed foods are needed in only a small number of instances. It is very important that persons, who have illnesses which require extra amounts of rationed foods, should receive the fullest consideration from food rationing authorities."

Captioned "Additional Facts To Be Considered", appeared the following statement:

"In administering the regulations concerning health needs, the following considerations will be helpful:

"A. For most rationed foods there are satisfactory non-rationed substitutes. Generally, fresh fish and poultry are excellent meat alternates. Fresh fruits and vegetables can be used for rationed processed foods, when available.

"B. The recommendations are written in terms of maximum quantities. Therefore, two deductions have been made in the meat-fats column of the table showing allowance of ration points.

"(1) Deductions for available alternates (fish and poultry). Since poultry and fresh fish are not rationed, applicants are expected to fill at least 25 per cent of their total meat, fish, and poultry requirements by using these items when they are obtainable. Therefore, the meat-fats column has been sub-divided into 'Available' and 'Not Available'.

"(2) Deductions for ration currency available through regular issuances of ration books to consumers have been made.

"C. The only deduction made from the processed foods allowance was the consumers regular ration of 12 points per week. Because of seasonal and regional supply variations, no deduction was made for fresh fruits and vegetables which may or may not be available.

"D. The Council recommends extra amounts of processed foods be given automatically **only** for individuals who have diabetes mellitus or active tuberculosis.

"E. It is not the intent of the Council that personal habits and tastes should be considered. 'Meat' is not necessarily to be interpreted in terms of 'beef' only, nor in terms of choice cuts which have high point values.

"F. The National Research Council's Subcommittee on Medical Food Requirements has further recommended that oleomargarine, when fortified with Vitamin A, is nutritionally equivalent to butter.

"G. The issuance of extra rations for minor miscellaneous ailments must be discouraged."

PERSONNEL OF COMMITTEE

The Subcommittee on Medical Food Requirements, National Research Council, is composed

of physicians representing various fields of medicine, and consisted of Dr. William Stroud, Philadelphia, chairman; Dr. Cecil Striker, Cincinnati; Dr. Alton Oschner, New Orleans; Dr. C. W. Munger, New York; Dr. Clark Finnerud, Chicago; Dr. Gilbery Levy, Memphis, and Dr. Walter W. Palmer, ex-officio, New York. Other committees of the Division of Medical Sciences were called into consultation, notably the Committee on Surgery and Subcommittee on Tuberculosis. The opinions of individual specialists in certain fields of medicine were solicited. All recommendations of the Subcommittee were reviewed and approved by the parent Committee on Drugs and Supplies before transmission to the War Food Administration.

Coming Meetings

Ohio State Medical Association, Columbus, May 2-4.

American Medical Association, Chicago, June 12-16.

American Association for the Surgery of Trauma, Chicago, June 9-10.

American Association for Thoracic Surgery, Chicago, May 5-6.

American Association of Genito-Urinary Surgeons, Stockbridge, Mass., June 8-10.

American Association of Industrial Physicians and Surgeons, St. Louis, May 8-11.

American Association of Plastic Surgeons, Philadelphia, May 25-27.

American Association on Mental Deficiency, Philadelphia, May 11-15.

American Broncho-Esophagological Association, New York, June 6.

American Laryngological Association, New York, June 7-8.

American Laryngological, Rhinological and Otological Society, New York, June 9-10.

American Neurological Association, New York, May 19-20.

American Ophthalmological Society, Hot Springs, Va., May 29-31.

American Psychiatric Association, Philadelphia, May 15-18.

American Psychoanalytic Association, Philadelphia, May 13-15.

American Society for Clinical Investigation, Atlantic City, May 8.

American Therapeutic Society, Chicago, June 10.

Association of American Physicians. Atlantic City, May 9.

Society of American Bacteriologists, New York, May 3-5.

Crile General Hospital, Newest Army Institution, Dedicated

Crile General Hospital, Parma Heights, the newest of the general hospitals constructed by the Army, was dedicated on April 21.

Dedication date followed a little more than a year after the day ground was first broken for the buildings. Today the 86 buildings of the hospital unit on a plot of ground of 152 acres stand ready to house the 1700 patients and 1200 members of the staff.

Army general hospitals are named for deceased Army medical personnel who, during their careers, have reflected great credit on themselves and their profession. This hospital is named for Dr. George W. Crile who led the Lakeside Hospital Unit, composed of doctors and nurses from the Cleveland area, in World War I.

The first convoy of overseas patients arrived at Crile Hospital on April 8, directly from the hospital ship that brought them back from the European theater of war.

The hospital is built on the cottage plan. The buildings, the majority of them single-story constructions, are connected throughout by enclosed corridors, an arrangement that makes it possible for a man on crutches or in a wheelchair to go from one end of the hospital to the other without going outside or running into such barriers as stairs. Facilities include 15 standard wards, 9 combination wards, and 4 detention wards.

The hospital has also made provision for a recreation program, including a library, a gymnasium, a recreation hall which has regular performances of movies as well as traveling shows brought in by the USO and similar groups, and a complete inter-hospital radio system.

Physicians' Art Exhibit

The American Physicians' Art Association will have its seventh annual exhibit at the Annual Session of the American Medical Association, Stevens Hotel, Chicago, June 12-16. Through the courtesy of Mead Johnson & Co., Evansville, Ind., there will be no fees for hanging and no express charges either way. The type of art to be exhibited includes personal work of the following types of medium: oil portraits, oil still life, landscapes, sculpture, water color, pastels, etchings, photography, wood carving, leather tooling, ceramics and tapestries (needle work). All pieces should be sent preferably by railway express collect, automatically covered with $50 insurance. Exhibitors should send now for entry blanks to Dr. Francis H. Redewill, Secretary, A.P.A.A., Flood Building, San Francisco; one entry blank should be used for each medium in which it is desired to exhibit.

Fees For Medical Services Raised Through Changes In Ohio Emergency Maternity and Infant Care Program

THE Ohio Department of Health has received approval from the U. S. Children's Bureau of certain amendments to the Ohio Plan for the administration of the Emergency Maternity and Infant Care program for wives and infants of servicemen. All applications for participation in the Emergency Maternity and Infant Care program received on and after April 10, 1944, are being approved in accordance with these amendments.

A detailed description of the Ohio Plan for the administration of the Emergency Maternity and Infant Care program was provided in the September, 1943, issue of *The Ohio State Medical Journal.*

CONSULTATION SERVICES

Following is the provision regarding consultation service as amended:

Consultation Services—When in the opinion of the attending physician, advice or assistance from a qualified specialist in the various fields of medical practice is required, authorization for such consultation service may be provided when the physician requests such services by a letter addressed to the Chief of the Division of Child Hygiene, Ohio Department of Health, specifying the reasons for such consultation, and the name and address of the consultant. In cases of unusual complications and emergencies, the attending physician may call in a qualified specialist, and the services of such a qualified specialist may be authorized providing the attending physician notifies by letter, the Chief of the Division of Child Hygiene, Ohio Department of Health, within three (3) days, that such a qualified specialist had been called, stating the reason for the consultation or assistance, the name and address of the consultant called, and the type of service performed by the consultant. When the authorization is approved by the Chief of the Division of Child Hygiene, Ohio Department of Health, payment will be made by the Ohio Department of Health in accordance with the rates established in this plan.

The attending physician, under the amended procedure, will request consultation by letter rather than by using Form MCH-1 or Form MCH-2. When it is necessary for the attending physician to secure consultation in an emergency, the period of time has been increased from 48 hours to three days for the attending physician to request from the Chief of the Division of Child Hygiene, Ohio Department of Health, by letter, authorization for such services.

HOSPITALIZATION PROCEDURE

As amended, the provision for hospitalization of the patient reads as follows.

Hospital Services—(Paragraph 2) In an emergency, the attending physician may hospitalize a patient eligible for participation in the emergency maternity and infant care program, and payment for hospitalization may be approved, providing the attending physician submits to the Chief of the Division of Child Hygiene, Ohio Department of Health, an official request for authorization for hospitalization and medical care on Form MCH-1 or MCH-2 within three (3) days after the patient is admitted to the hospital.

In case of emergencies the period of time has been extended from 48 hours to three days for the attending physician to notify, by letter, the Chief of the Division of Child Hygiene, Ohio Department of Health, of the necessity of hospitalizing a patient eligible for participation in the Emergency Maternity and Infant Care program.

Payment for consultation and emergency hospitalization can not be made unless an authorization for such services has been secured from the Chief of the Division of Child Hygiene, Ohio Department of Health.

MEDICAL FEES INCREASED

Increases in fees for medical services are made through amendments to the following sections:

(9) Payment for Medical Care.

(a) Maternity Care—The fee to be paid to a physician for complete medical care which includes all medical services he renders the patient during the antepartum period, labor and puerperium, as well as care of complications, obstetrical operations, if needed, postpartum care, care of the newborn infant, postpartum examination six (6) weeks after delivery, routine blood test for syphilis, hemoglobin determination, urinalyses and other similar services, shall not exceed $50.00. This maximum payment of $50.00 will be provided as follows: A maximum of $15.00 for prenatal care at $2.00 per office visit and $3.00 per home visit; $30.00 for delivery, and $5.00 for the postpartum examination six (6) weeks after delivery. When pregnancy terminates in spontaneous abortion, a maximum payment of $15.00 will be provided in addition to the payment provided for prenatal care visits. Payment to physicians will only be provided for services rendered on and after the effective date of authorization for medical care. When complete medical care is not provided, payment will be made in accordance with the above schedule for services rendered.

(b) Health Supervision and Medical Care for Infants—Initial authorization for medical care for sick infants shall cover a period not to exceed three (3) weeks and shall provide for payment as follows. Home visit $3.00; hospital or office visit $2.00. The total amount paid shall not exceed $12.00 for the first week of care and $6.00 for each succeeding week of care. When in the opinion of the attending physician additional medical care is required, a request for approval of additional authorization may be submitted by a letter addressed to the Chief of the Division of Child Hygiene, Ohio Department of Health,

stating the reason for such a request. Upon review of such request, the Chief of the Division of Child Hygiene, Ohio Department of Health, may grant additional authorization for a period not to exceed three (3) weeks.

INCREASES EXPLAINED

Payment for complete medical care has been increased from $40.00 to $50.00. A maximum amount of $15.00 is now provided for prenatal care, at a rate of $2.00 for office visits and $3.00 for home visits, which have been provided after the effective date of authorization. A maximum of $30.00 is now provided for delivery, and a maximum of $5.00 for the post-partum visit six weeks after delivery. Provision is now made for payment for the medical care of spontaneous abortion.

The payment for medical care of sick infants has been increased from $10.00 to $12.00 for the first week of care. When additional care is necessary the attending physician will make such a request by letter, stating the reason for such additional care, rather than by using Form MCH-2

FEES FOR CONSULTANTS

Fees for consultants for special procedures are provided in the amended plan, reading as follows:

(c) Consultation Service—Qualified specialists, when called by the attending physician, may be paid not more than $10.00 for advice or assistance rendered the attending physician.

Qualified specialists, when called by the attending physician, may be paid not more than $25.00 for such procedures as manual removal of the placenta; repair of extensive perineal tears; version and extraction; cervical repair; unusual cases requiring forceps delivery; and pediartric procedures involving minor surgery.

Qualified specialists, when called by the attending physician, may be paid not more than $50.00 for major surgical procedures.

In addition to the maximum fee of $10.00 which has been provided for consultation services, provision is made to provide not to exceed $25.00 for certain obstetrical and pediatric procedures involving minor surgery. The maximum fee for major surgical operations has been increased from $40.00 to $50.00.

In order that consultants may be paid, it is necessary that the attending physician request authorization for such services within three days after the services have been rendered to a patient eligible to participate in the Emergency Maternity and Infant Care program.

The Ohio Department of Health has been notified by the Children's Bureau that when hospitalization is not requested by the attending physican, a statement should be provided on the application form stating that the applicant will be delivered at home or will use hospital insurance.

Washington Office Is Opened By the A.M.A.

THE following announcement was published in the April 8, 1944, issue of The Journal of the American Medical Association:

"An Office of Information in Washington, D.C., was opened on April 3 by the Council on Medical Service and Public Relations of the American Medical Association. It is located in suite 900, Columbia Medical Building, 1835 I Street, Northwest. A large number of booklets, pamphlets and other published material are being sent to Washington, where they will be readily available to those desiring information concerning the various fields of medicine and the activities of the Association."

New Diarrhea and Enteritis Control Service Offered

Announcement is made by the Michigan Department of Health and the W. K. Kellogg Foundation that a diarrhea and enteritis study group which has been in training for a year is now ready to give assistance to hospitals experiencing active outbreaks of nursery diarrhea.

The study group is in charge of a licensed physician and is made up of two sections, one working in the field and the other in the laboratory.

The field section consists of a physician, two graduate nurses and a medical secretary. This staff will collect clinical, epidemiologic, sanitary and laboratory data and give clinical and control assistance. Additional medical, nursing and engineering specialists will be recruited locally when needed and paid from study funds.

The laboratory section is composed of two bacteriologists, one virologist, five laboratory assistants and one secretary. This group has been especially trained and equipped to analyze all types of laboratory specimens sent in from the hospitals.

Field operations will be limited to Michigan, Northern Ohio and Northern Indiana. Any hospital experiencing an active outbreak of nursery diarrhea may request the services of the study group. The cost of field operations will be borne by the W. K. Kellogg Foundation and the department. Requests should be made by telephone to Dr. C. C. Young, Director of Laboratories, Michigan Department of Health. The project has the endorsement of the Ohio Department of Health.

Ohio's Program for Vocational Rehabilitation Under the Provisions of Recently Amended Federal Act

EDWARD HARLAN WILSON, M.D., Columbus, Ohio

THE new Rehabilitation Law, Public Law No. 113, as passed by the 78th Congress, will affect medicine in all of its branches. The law is an amendment to an original act passed in 1920 which provided for "the promotion of vocational rehabilitation of persons disabled in industry or otherwise and their return to civil employment". As amended it provides, in addition to vocational training and the providing of jobs, for "corrective surgery or therapeutic treatment necessary to correct or substantially modify a physical condition which is static and constitutes a substantial handicap to employment, but is of such a nature that such correction or modification should eliminate or substantially reduce such handicap within a reasonable length of time". It includes hospitalization up to 90 days, transportation, prosthetic devices and maintenance during training or treatment. The funds are provided on an equal basis by the Federal Government and the state, under the direction of the Bureau of Vocational Training, Federal Security Administration, through the State Director of Vocational Rehabilitation, who, in Ohio, is Mr. M. B. Perrin.

Editor's Note

● **Believing that the Ohio Vocational Rehabilitation Program, soon to be inaugurated under the provisions of the amended Federal Rehabilitation Law, is a question of vital importance to the medical profession, as it provides for "corrective surgery or therapeutic treatment" for those eligible to participate in its benefits, *The Journal* requested Dr. Edward Harlan Wilson, Columbus, a member of the State Advisory Council to the State Director of Vocational Training and chairman of the Medical Advisory Committee, to prepare the accompanying article. Dr. Wilson recently discussed this question with The Council of the Ohio State Medical Association, which extended to him and his committee the cooperation and facilities of the Association in working out the details for the Ohio program.**

MEDICAL ADVISORY COMMITTEE NAMED

The Federal Act is further implemented by the acceptance on the part of the Federal Bureau of a state plan set up by Mr. Perrin. This plan calls for the formation of an Advisory Council made up of the various agencies which contribute to rehabilitation. The medical members of this council are myself, Dr. John Romano, psychiatrist of Cincinnati; Dr. Walter Zeiter, Director of Physiotherapy, Cleveland Clinic.

In turn the chairman of the council, Dean Leonard Mayo of Western Reserve University, has asked me to form a Medical Advisory Committee. Before forming such committee we conferred with President Sherburne and other officials of the Ohio State Medical Society. Following such conference the following men were invited to membership and have accepted: Dr. Clarence Heyman, Cleveland, Ohio; Dr. Joseph Freiberg, Cincinnati, Ohio; Dr. Barney J. Hein, Toledo, Ohio; Dr. Charles Doan, Columbus, Ohio; Dr. Myron Miller, Columbus, Ohio; Dr. Albert Frost, Columbus, Ohio; Dr. Arnold Sydow, Cleveland, Ohio; Mr. R. M. Porter, Columbus, Ohio; Dr. Walter A. Hoyt, Akron, Ohio; Dr. John Romano, Cincinnati, Ohio; Dr. Walter Zeiter, Cleveland, Ohio; Dr. Harold Feil, Cleveland, Ohio; Colonel Claude Beck, Cleveland, Ohio; Miss Bell Greve, Cleveland, Ohio.

This Committee has been asked to consider the following problems: A method of supervision of medical care to pass upon applications for treatment of disabled individuals; determination of the necessary qualifications for the various branches of medicine and surgery; a medical fee schedule, standards of hospitalization and the basis for determination of hospital charges.

PROPOSED OHIO PLAN

In the Ohio plan, in addition to the committees as above described, it is proposed at this time to divide the state into seven districts, each grouped around one of the larger cities and it is the purpose of Director Perrin to make each district as self-suffiicient as possible. In each district there would be several agents of the department who would follow up appropriate cases, see that they are examined and follow them through to see that proper follow-up measures are taken including physiotherapy and vocational training.

It should be realized that the purpose of the plan is to restore men and women to industry and that medicine and surgery as used are purely

incidental to that purpose. It is presumed that the individuals dealt with would be needy persons who are unable to earn their living because of their disabilities. The plan states definitely that individuals who have access to other funds such as the Workmen's Compensation Fund, industrial insurance, etc., are not included under the act nor are those who are able to pay out of their own pockets for such services.

PROBLEMS ARE DIFFICULT

The intent of the law seems clear and justifiable and the members of the Medical Advisory Committee have accepted appointment on this understanding. As such, the law constitutes a challenge to the medical profession which will have the opportunity of showing what it can contribute in the way of restoring individuals to an independent life by removing them from the dependency rolls.

The problems facing the committee are difficult. It is clear that in certain specialized forms of medicine and surgery, qualifications of some sort will have to be adopted if the work is to be carried on fairly. At the same time, it is our feeling that the work should be localized to the home community as much as possible. It will, however, require time to develop all the necessary facilities in some of the smaller cities although we feel that such centers should be developed as quickly as possible. The question of medical supervision could be worked out in two ways; either by setting up a list of acceptable consultants in various parts of the state with the purpose of decentralization, or by the more ordinary method of a full or part-time physician administering the medical and surgical part of the program from the central office. The Medical Advisory Committee would appreciate suggestions and advice from physicians in the state who may care to pass them on to us. They may be addressed to the chairman of the committee, Edward Harlan Wilson, M.D., 395 E. Broad Street, Columbus 15, Ohio.

COOPERATION OF DOCTORS REQUESTED

In conclusion, we would like to call attention to the fact that the wording of the law is very broad and that, in the strictest sense, almost any remediable chronic illness is covered. Tuberculosis and mental diseases are very definitely included. Certain forms of heart disease and many other conditions likewise are included. The final test may be the question of whether a condition can be improved in an individual to the point where that individual may regain his ability to support himself. We intend to represent the medical profession as a whole and we ask your sympathy and tolerance while working out the details of a plan which may be very far reaching in its effect.

Government Hospitals In Need of Occupational Therapists

The U.S. Civil Service Commission has issued a call for additional trained occupational therapists for Army and Veterans' hospitals.

As increasing numbers of injured soldiers return to the hospitals, more and more occupational therapists are needed to aid in their adjustment to normal life. In greatest demand are experienced graduates of accredited occupational therapy schools. Experience should be in hospitals acceptable to the American Medical Association. For some positions, however, college training in psychology and in arts and crafts or trades and industries, or experience as a junior aide in Veterans' hospitals may be substituted for training in occupational therapy schools. Other positions will be filled by inexperienced graduates of occupational therapy schools.

The salary range of these positions is $1,970 to $2,433 a year, including overtime pay. Those appointed at $1,970 will be trainees for a period of 18 months; those appointed at $2,190 and $2,433 will administer occupational therapy under medical and general supervision, in Army and Veterans' hospitals. There are no age limits and no written tests, but applicants must be physically capable of performing the duties involved.

Further information on positions and forms for applying can be obtained from first- and second-class post offices or from the United States Civil Service Commission, Washington 25, D.C.

Cardiovascular Instruction

The cardiovascular department of the Michael Reese Hospital, Chicago, is offering a full-time, intensive course in electrocardiography for two weeks, August 21 to September 2, under the direction of Dr. Louis N. Katz, director of cardiovascular research. The course is for general practitioners and internists. It is planned to individualize the course by group conferences so that at the end of the period each student will be capable of properly interpreting electrocardiograms. In order to accomplish this purpose the class will be limited in number. Reservations should be made early. An hourly program of the course will be sent on request. For further information address Michael Reese Hospital, Cardiovascular Department, 29th and Ellis Avenue, Chicago 16, Ill.

Cleveland—Members of the Kiwanis Club were told by Dr. Robert M. Hosler of the Cleveland Academy's public education committee, that benefits proposed through compulsory medical and hospital insurance could be satisfactorily obtained by expansion of existing private agencies.

American Bar Association Severely Condemns Wagner Bill In Adopting Special Report At Recent Meeting

ON February 28, 1944, the House of Delegates of the American Bar Association adopted a lengthy report prepared by a special committee, which had been appointed to study the Wagner-Murray-Dingell Bill, condemning the proposal. Thus the name of another intelligent, influential group outside the medical profession is added to the growing list of organizations which sense the dangers inherent in Senator Wagner's bill.

The bar association leads with its left by calling attention to the fact that the socialized medicine section of the bill "leaves the reader in utter confusion as to its meaning or extent" because it is "replete with involvement, cross references, new terminology, percentages and other confusing matters". The report cites many sections of the proposal as examples of conflicting and confusing provisions.

STATEMENTS MISLEADING

Following with a hefty right jab, the report declares that the statements made by Senator Wagner on June 3, 1943, relative to the bill are not entirely accurate, or are misleading, citing the following inaccuracies:

"1. Senator Wagner states: S. 1161 is unlike the British proposal, which is the Beveridge plan with all doctors required to be salaried officers of the government.

"The statement is misleading. Both plans look toward a system of medicine supervised, regulated and controlled by government. Under S. 1161 all doctors will be paid by the government, for in time there will be no private practice.

"2. Senator Wagner states: There is complete freedom of choice of doctor by patient.

"This is incorrect. If either the patient or the doctor named on the panel by the Surgeon General declines to accept the other, the patient is assigned to some other doctor.

"3. Senator Wagner states: There is complete freedom of choice of hospital by patient.

"This statement is incorrect. There is no provision for freedom of choice of hospital. The entire system is under regulation by the Surgeon General.

"4. Senator Wagner states: There is freedom of medical practice for the doctor.

"This is misleading. The plan is so extensive that in time there will be no private practice.

"5. Senator Wagner states: There is freedom of types of remuneration for the doctor.

"This is misleading. The doctor is forced on a salary or on a fee basis or on a combination of the two, as determined by the Surgeon General, who approves the fee tables.

"6. Senator Wagner states: There is freedom of types of remuneration for the hospital.

"This is incorrect. Hospital rates are determined by the Surgeon General with the approval of the Social Security Board.

"7. Senator Wagner states: No doctor is forced into the insurance system.

CLIP AND SAVE

Clip and save this article for your Wagner Bill File. You will find it handy for future reference.

"This is misleading. He must go into the insurance system or be faced economically to cease the practice of medicine.

"8. Senator Wagner states: No doctor is forced on a salary basis.

"This is misleading. The doctor is forced on a salary or on a fee basis, or on a combination of the two, as determined by the Surgeon General.

"9. Senator Wagner states: Arrangements for obtaining medical, laboratory or hospital care would be essentially as they are now in this country, except as to payment out of the insurance fund.

"This is entirely incorrect. The whole medical system is supervised, regulated and controlled by government.

"10. Senator Wagner states: Voluntary hospitals are eligible to participate in the plan.

"This is misleading. They may participate if selected by the Surgeon General.

"11. Senator Wagner states: The system would promote the personal relations between doctor and patient.

"This is an expression of opinion. The experience of foreign countries shows an opposite result.

"12. Senator Wagner states: The Canadian system recently proposed is similar to S. 1161 and has the support of the Canadian Medical Association and the Canadian Hospital Council.

"This is incorrect and misleading. The Canadian plan provides for its adoption by the provinces (or states) with a local full time doctor in charge. Both the Canadian Association and the Canadian Council are sharply critical of the plan."

EFFECT ON MEDICAL SERVICE

The one-two punch is delivered in the following discussion of medical service in the United States and the effects of the Wagner Bill on such service:

"1. Under the medical care now provided in the United States the highest level of health and the lowest death rate ever known under similar conditions are being maintained.

"2. There are being developed in this country and under our system of free enterprise many plans for providing adequate medical care without paying the price of socialized medicine. These include group and hospital insurance and Blue Cross plans under principles approved by the medical profession. The Blue Cross plan beginning in 1933 and now covering more than fifteen million people provides for the moderate means class, on which hospital bills fall heavily.

"3. The indigent, who are most in need of free medical care, are not covered by S. 1161.

"4. Forty-two per cent of the expenditures for hospital services and for doctors' services ren-

dered hospital patients in 1942 were either tax supported or otherwise without cost to the patient and without recourse to federal regulation and control as proposed.

"5. Of all like plans now in effect in foreign countries, none is comparable with the plan proposed by S. 1161 except the Russian system, which involves the complete socialization and regimentation of medicine. Such a pattern, if allowed in this country, will inevitably produce a like result. The physician will become merely an unambitious federal employee or a politically ambitious doctor.

"6. Contrary to assertions of the advocates of the measure, the plan covers practically the entire population of the United States except the indigent.

"7. To safeguard a minimal percentage of the population which has difficulty in obtaining complete medical service, the bill would put all the people in a medical strait jacket under the supervision of the federal government for an alleged service which the vast majority either do not require or are able to provide for themselves.

"8. The measure will inevitably lessen the interest of the physician in his patient as an individual and dull the incentive to produce the best results. The patient will become the guinea pig supplied by the government as the excuse for the payment of subsidies to a controlled profession for its routine services. This would disturb the social order of which both are members and result in vital loss both to the community and to the doctor.

"9. The measure will subject to bureaucratic control and supervision the intimate and confidential relationship between doctor and patient and make confidential information resulting therefrom available to employees of the government.

"10. Medical education and training which have attained an unequaled standard of excellence in institutions conducted under our system of free enterprise, would under S. 1161 be subsidized, regulated and controlled by government.

"11. Within the past twenty years the center of medical progress has moved from Germany, Austria and England, which have adopted some form of state medicine and which previously served as centers of postgraduate medical education, to the United States, and we now find physicians and hospital administrators coming for guidance and inspiration to this country, where no form of state medicine is in effect."

RIGHTS OF PEOPLE ENDANGERED

Stepping in for the "kill", the bar association's delegates put over the knock-out punch in the following concluding statement:

"The American Bar Association is limited to an expression of opinion and judgment with respect to those fields which relate to the administration of justice and which directly affect the safeguards and protection of the rights and liberties of the citizens of this country. Under normal circumstances, therefore, it is not the function of this association to attempt to influence substantive legislation by the Congress of the United States. But when under the pretext of the general welfare legislation is proposed in Congress which either inadvertently or with deliberate subtlety constitutes a direct attack on the rights and liberties of the citizens of this country, it becomes the duty of this association actively to voice its objections, a summary of which is as follows:

"1. Local self government must be preserved in our federal system. State governments directly responsible to the will of the people are best adapted to exercise such supervisory control as may be instituted over the health and medical care of our citizens.

"2. S. 1161 seeks to invest in the Surgeon General, who is not an elected servant of the people and who is not amenable to their will, the power arbitrarily to make rules and regulations having the force and effect of law which directly affect every home.

"3. The measure furnishes the instrumentality by which physicians for their practice, hospitals for their continued existence and citizens for their health and that of their families can be made to serve the purposes of a federal agency.

"4. The bill fails to safeguard the rights of patients, citizens, hospitals or doctors with respect to disputes arising or rights denied through the arbitrary or capricious action of one man.

"5. The bill fails to provide for any appeal to any court from the action of the Surgeon General.

"6. The vicious system whereby administrative officials judge without court review the actions of their subordinates in carrying out orders issued to them is extended in this bill to a point foreign to our system of government and incompatible with the adequate protection of the liberties of the people.

"The Constitution of the United States is designed to protect the citizens of this republic in the exercise of the rights of free men. The provisions of that instrument can be rendered impotent when our citizens, for the sake of an apparent immediate benefit, surrender to their government such direct control over their lives that government, by imposing a constant fear on them of having those benefits withheld or withdrawn, can compel from them obedience and subservience to its dictates."

The complete text of the special report adopted by the American Bar Association's delegates was published in the March 11, 1944, issue of *The Journal of the American Medical Association.*

Speakers at Safety Conference

Ohio physicians who participated in the program of the Fifteenth All-Ohio Safety Conference at Columbus on April 18-20, included the following: Dr. Robert Kehoe, Cincinnati, "Wartime Medical Aspects of Handling Gasoline Blending Agents"; Dr. H. P. Koehler, Findlay, "Industrial Safety from the Standpoint of Rehabilitation of Workmen"; Dr. L. C. Hatch, Akron, "Wartime Problems of Health and Safety in the Aircraft Industry"; Dr. R. C. McKay, Cleveland, "Silicosis"; Dr. Ben Arnoff, State Industrial Commission, Columbus, "What Is An Occupational Disease?—Its Diagnosis, Management and Prevention"; Dr. R. E. S. Young, Columbus, "Value and Scope of Plant Medical Department".

Rights of Self-Insuring Employer in Furnishing Medical Services Analyzed in Opinion of Attorney General

IN compliance with a request filed by the State Industrial Commission, Attorney General Thomas J. Herbert has rendered the following opinion (No. 6546) pertaining to the right of a self-insuring employer under the Workmen's Compensation Act to require an injured employee to accept the services of a physician or physicians provided by the employer and the authority and discretion of the Industrial Commission in medical cases involving self-insuring employers and employees of such employers:

SYLLABUS

"The Industrial Commission of Ohio does not have authority to grant an injured employee of a self-insuring employer the right to select medical, hospital or nursing services of his own choice, except in an emergency where the employer is unable to select and furnish the services (Annual Report of Attorney General, 1914, Vol. II, 1556, approved and followed).

"Furnishing medical, hospital and nursing services by a self-insuring employer that are clearly inadequate or incompetent does not give an injured employee the right to substitute services of his own choice so as to render the employer liable therefor, unless the employee has first secured authorization from the Industrial Commission to engage said services.

TEXT OF OPINION

"A determination of the questions set forth in your request involves an interpretation of that portion of Section 1465-69, General Code, relative to self-insuring employers, which states:

'* * * And provided further, that such employers who will abide by the rules of the industrial commission of Ohio and as may be of sufficient financial ability to render certain the payment of compensation to injured employes or the dependents of killed employes, and the **furnishing of medical, surgical, nursing and hospital attention and services and medicines, and funeral expenses** equal to or greater than is provided for in sections 1465-78 to 1465-89, General Code, and who do not desire to insure the payment thereof or indemnify themselves against loss sustained by the direct payment thereof, may, upon a finding of such fact by the industrial commission of Ohio, elect to pay individually such compensation, and **furnish such medical, surgical, nursing and hospital services and attention and funeral expenses** directly to such injured or the dependents of such killed employes; * * *' (Emphasis mine.)

"The requirement in this section relative to medical, surgical, nursing and hospital attention for injured employees of self-insuring employers calls for an interpretation primarily of the words 'furnish' and 'furnishing'. Webster's New International Dictionary defines 'furnish' as 'To provide for; To provide what is necessary for; To fulfill or satisfy the needs of.'

FORMER OPINION CITED

"In Annual Report of the Attorney General for 1914, Vol. II, at page 1556, one of my predecessors had occasion to interpret Section 22 of the Workmen's Compensation Act (103 Ohio Laws, 72), pertaining to the furnishing of medical, hospital and nursing services, which section contained, in so far as the present inquiry is concerned, the same language as that in Section 1465-69, above quoted. In that opinion it was held in the syllabus:

'The industrial commission has authority to permit employers carrying their own insurance under section 22 of the workmen's compensation act to require employees of such company to receive medical attendance and hospital and nursing services from the physicians, surgeons, and hospitals maintained by such company. If the employe calls upon physicians other than those employed by such company, the employer is not liable for the expenditure so incurred by such employe. This is a general rule and is subject to modification under exceptional circumstances, such as those which might arise when the company surgeons or physicians were unable by reason of absence or from some other cause to furnish the necessary medical attendance to the employe in case of emergency. This is especially true when the employe has first resorted to one of the company physicians and has later gone to another physician not in the employ of the company, for no valid reason.'

"As no change has been made in the section since the rendition of the 1914 opinion, I see no reason for amending or altering the rationale contained therein.

AUTHORITY OF COMMISSION

"While it is my belief that said opinion answers your questions, inquiry is made as to what authority the Industrial Commission would have to authorize medical, nursing and hospital services to be performed by parties of claimant's choice or to order a self-insuring employer to pay therefor according to the scheduled rates where it was definitely shown that such services furnished by the employer were inadequate or incompetent.

"Certainly, from the ordinary definition of the word 'furnish' or 'furnishing', if a situation were to occur where the employer furnished inadequate or incompetent services, the Industrial Commission would not only have authority, but would have the duty to order the employer to pay for adequate services necessary for the treatment of an employee's pathological condition. However, Rule 23 of the Industrial Commission (Important Resolutions, Rules, Motions and Instruc-

tions issued by the Industrial Commission of Ohio—revised October 1, 1942) provides:

'Surgery, Authority For. * * *

'Except in emergencies or where the condition of the patient might be endangered by delay, consent from the Commission must be obtained in advance where any surgery is contemplated. * * *' (Emphasis mine.)

MUST GET AUTHORIZATION

"Under this rule the Industrial Commission, we believe, would have authority to substitute adequate services for inadequate services furnished by the employer, but an employee still could not select his own surgeon, nurse or hospital without first obtaining from the Industrial Commission, as provided by said rule, an authorization for such selection. Should the claimant, even though inadequate service is furnished, on his own volition, secure his own services without complying with the above quoted rule, we believe the Industrial Commission would not have authority to order the employer to pay for such services.

"As stated in the syllabus of the opinion hereinbefore quoted, the general rule is subject to modification under exceptional circumstances; for example, in a situation in which an emergency arose and where the employer's physicians or surgeons were not then available, it is probable that the employer would be required to pay for the services performed even though the claimant had selected a physician of his own choice prior to an authorization by the Industrial Commission. However, if the employee's physical condition was such that an emergency, requiring immediate surgical or medical attention, did not exist, then the claimant could not select the services of his own choice, and the Industrial Commission would not have authority to order the employer to pay for the services selected and used by the employee."

REPORT ON ANNUAL MEETING TO BE PUBLISHED IN JUNE ISSUE

Complete details regarding the Ninety-Eighth Annual Meeting of the Ohio State Medical Association, including the minutes of the sessions of the House of Delegates, held in Columbus, May 2, 3 and 4, will be published in the June issue of The Journal.

Medical Correctional Association Is Seeking New Members

The Medical Correctional Association, an affiliate of the American Prison Association and an organization of persons interested in the medical and psychological approaches to crime, is now engaged in a drive to increase its membership. Interested parties are urged to communicate with Robert M. Lindner, Secretary-Treasurer, Medical Correctional Association, Lewisburg, Pennsylvania, for further information. Dues are $1.00 per year, entitling the payee to voting privileges, all communications and literature.

Its membership includes physicians who recognize the uniqueness of institutional practice and wish to exchange ideas and opinions regarding their work; psychiatrists and psychologists who find in prisons a challenging field for research and study; social workers who appreciate the significance of the modern orientation in criminology; probation, parole and administrative personnel who feel the need for stimulation of contact with the broader and more basic implications of their assignments.

Meetings of the Medical Correctional Association are held concurrently with the conventions of the parent body; and always include at least one independent session devoted solely to the exchange of ideas and research encompassed by the field.

Proposed Federal Laws

Following are excerpts from a recent Federal Legislative Bulletin of the Bureau of Legal Medicine and Legislation of the American Medical Association on certain medical and health proposals:

A bill, S. 1633, to amend the nurses' training act, was passed by the U. S. Senate. It proposes that the head of any department, establishment or other federal agency may request and accept transfers of student nurses, who are transferable under the original act, to a federal hospital operated by his agency in continental United States, exclusive of Alaska. It provides for the continued training of such student nurses requisite to graduation. That training period may not extend beyond the period for graduation by the institution from which the student nurse was transferred and may be terminated at any time prior thereto as the interests of the service may require.

The appointment of optometrists as commissioned officers in the Army and Navy Medical Corps by the President on recommendation of the Surgeons General is proposed in H.R. 4063 pending before the House Committee on Military Affairs.

H.R. 1506, pending before the same committee, would permit service in the Medical Reserve Corps to be counted by medical officers for pay purposes.

Names of 13 Additional Ohio Physicians Added to the Military Roster, Which Now Totals, 2,778

THE names of 13 physicians were added to the military roster of the Ohio State Medical Association during the past month. After the names of the physicians discharged from the services had been deducted, the roster of those on active duty totalled 2,778 as of April 20. Of the total, 2,361 are in the Army; 348 in the Navy and 69 in miscellaneous governmental services. The names of those entering the services during the past month; those promoted; and the tabulation by counties, follow:

NAMES ADDED TO MILITARY ROSTER

Name	City	Rank
Cooper, Paul F.	Cleveland	1st Lt., U.S.A.
Ebenstein, Benno	Columbus	1st Lt., U.S.A.
Eddy, Ford E.	Marietta	Lt., U.S.N.
Hanysh, Myron C.	Youngstown	1st Lt., U.S.A.
Hawkins, George L.	Cleveland	1st Lt., U.S.A.
Kuehn, Conrad A.	Gallipolis	Capt., U.S.A.
Lasky, Lester	Zanesville	Lt. Comdr., U.S.N.
MacDonald, Wm. E.	Cleveland	Lt. (j.g.), U.S.N.
Rea, Frederick W.	Marion	Lt., U.S.N.
Scherer, John R.	Portsmouth	1st Lt., U.S.A.
Shapiro, Nathan	Cincinnati	1st Lt., U.S.A.
Speier, Jos. W., Jr.	Wyoming	1st Lt., U.S.A.
Tapper, Ralph W.	Dayton	1st Lt., U.S.A.

WIN PROMOTIONS

Name	City	Rank
Alley, John R.	Greenville	Major, U.S.A.
Barnhiser, Von Bergen	Camden	Major, U.S.A.
Berry, Clyde W.	Wapakoneta	Major, U.S.A.
Bershon, Albert L.	Toledo	Lt. Col., U.S.A.
Birkbeck, Norman J.	Dayton	Comdr., U.S.N.
Bonar, L. D.	Mansfield	Capt., U.S.A.
Borelli, John F.	Hamilton	Major, U.S.A.
Briola, Patsie F.	Cleveland	Lt. Col., U.S.A.
Brown, Harry G.	Cincinnati	Major, U.S.A.
Brumbaugh, J. J.	Canton	Lt. Col., U.S.A.
Chapla, Albert B.	Lorain	Capt., U.S.A.
Clark, John J.	Mansfield	Capt., U.S.A.
Cole, Allan A.	Logan	Major, U.S.A.
Cooper, Maurice P.	Toledo	Major. U.S.A.
Damstra, Eugene F.	Dayton	Major, U.S.A.
Doeing, Carl T.	Springfield	Lt. Col., U.S.A.
Duncan, Wallace S.	Cleveland Heights	Lt. Col., U.S.A.
Eisenberg, Samuel H.	Akron	Major, U.S.A.
Elliott, Wm. S.	East Palestine	Major, U.S.A.
Elsey, Edward C.	Cincinnati	Lt. Col., U.S.A.
Freedman, Eugene	Cleveland	Lt. Col., U.S.A.
Freilich, Myron A.	Zanesville	Major, U.S.A.
Furste, W. L.	Columbus	Capt., U.S.A.
Grossman, Royal G.	Lakewood	Col., U.S.A.
Harner, Ronald M.	Canton	Capt., U.S.A.
Howland, Bernard U.	Wheelersburg	Capt., U.S.A.
Inskeep, Lewis	Urbana	Capt., U.S.A.
Junkerman, Carl S.	Columbus	Lt. Col., U.S.A.
Katz, Sidney	Cleveland	Capt., U.S.A.
Kennedy, Roscoe J.	Cleveland	Comdr., U.S.N.
King, T. A.	Cleveland	Capt., U.S.A.
Keyes, J. E. L.	Youngstown	Lt. Col., U.S.A.
Klatman, Samuel	Youngstown	Capt., U.S.A.
Kobacker, J. Lester	Toledo	Comdr., U.S.N.
Larsen, B. B.	Shaker Heights	Lt. Col., U.S.A.
Lawton, O. M.	Canfield	Comdr., U.S.N.
Lehrer, H. G.	Wadsworth	Lt., U.S.N.
Lichtblau, Abe A.	Canton	Capt., U.S.A.
List, Ellis W.	Andover	Comdr., U.S.N.
Matteo, Michael L.	Cleveland	Major, U.S.A.
McNamee, Regis J.	Cleveland	Major, U.S.A.
Meck, Floyd S.	Cleveland	Comdr., U.S.N.
Michael, Nicholas	Columbus	Lt. Col., U.S.A.
Miller, Isador	Urbana	Capt., U.S.A.
Namen, Jay M.	Cleveland Heights	Major, U.S.A.
Neill, W. A.	Toledo	Capt., U.S.N.
Nenninger, John R.	Silverton	Lt., U.S.N.
Nosik, Wm. A.	Cleveland	Lt., U.S.N.
Pease, Phillip P.	Chardon	Col., U.S.A.
Pollack, Alexander	Columbus	Capt., U.S.A.
Rowles, Donald F.	Columbus	Capt., U.S.A.
Sawan, E. A.	Akron	Major, U.S.A.
Schneble, R. C.	Dayton	Lt. Comdr., U.S.N.
Schroeder, N. C.	Kenton	Lt. Col., U.S.A.
Scroggin, Frederick R.	Cincinnati	Capt., U.S.A.
Scuderi, John J.	Akron	Capt., U.S.A.
Seebohm, Paul M.	Cincinnati	Capt., U.S.A.
Sharp, J. M.,	Cincinnati	Lt., U.S.N.
Sheehan, Wm. J.	Cleveland	Comdr., U.S.N.
Silver, Nathan	Cincinnati	Capt., U.S.A.
Smith, Kenneth M.	Columbus	Major, U.S.A.
Starbuck, Ralph J.	Salem	Capt., U.S.A.
Wallace, Richard H.	Bexley	Major, U.S.A.
Woolsey, Frank M.	Cleveland	Capt., U.S.A.
Yospur, David	Gallipolis	Capt., U.S.A.
Zeve, Herman S.	Youngstown	Comdr., U.S.N.

TABULATION BY COUNTIES

Adams	2	Guernsey	6	Muskingum	10
Allen	38	Hamilton	420	Noble	1
Ashland	11	Hancock	12	Ottawa	9
Ashtabula	17	Hardin	7	Paulding	2
Athens	12	Harrison	4	Perry	4
Auglaize	6	Henry	2	Pickaway	5
Belmont	12	Highland	8	Pike	2
Brown	4	Hocking	4	Portage	2
Butler	29	Holmes	2	Preble	7
Carroll	1	Huron	15	Putnam	6
Champaign	8	Jackson	1	Richland	38
Clark	31	Jefferson	30	Ross	24
Clermont	9	Knox	11	Sandusky	10
Clinton	7	Lake	18	Scioto	20
Columbiana	11	Lawrence	6	Seneca	12
Coshocton	4	Licking	17	Shelby	7
Crawford	9	Logan	8	Stark	98
Cuyahoga	682	Lorain	38	Summit	146
Darke	6	Lucas	156	Trumbull	26
Defiance	4	Madison	6	Tuscarawas	19
Delaware	7	Mahoning	118	Union	2
Erie	10	Marion	1	Van Wert	9
Fairfield	9	Medina	13	Vinton	2
Fayette	2	Meigs	3	Warren	4
Franklin	224	Mercer	6	Washington	8
Fulton	6	Miami	13	Wayne	14
Gallia	5	Monroe	1	Williams	8
Geauga	4	Montgomery	141	Wood	17
Greene	7	Morgan	3	Wyandot	3
Total					2778

Gifts for Nutrition Studies

Seven financial contributions, amounting to $34,000, to aid research studies in nutrition under Dr. Tom D. Spies, associate professor in the College of Medicine, highlighted a long list of gifts accepted for the University of Cincinnati at the Board of Directors' February meeting.

Included in the group were $5000 each from Anheuser-Busch, Inc., Lederle Laboratories, Inc., Eli Lilly & Co., the John and Mary R. Markle Foundation; Parke, Davis & Co., and the Upjohn Co., and $400 from the Ingalls Foundation.

Another contribution accepted was $650 from Bauer and Black to the department of surgery, to defray part of the expense of producing a motion picture on the treatment of traumatic wounds.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

MICHIGAN MEDICAL SERVICE NOW IN "THE BLACK"

Let those who said, "It can't be done", cogitate on the following editorial published in the April, 1944, issue of *The Michigan State Medical Journal*, captioned: "The Success of Michigan Medical Service":

"Good news to Michigan's medical profession is contained this month in the announcement that Michigan Medical Service now is 'in the black'.

"Not only has the organization been on a paying basis for a year and a half, but it has overcome a deficit which at one time threatened dissolution of the entire program.

"The Medical Service has just completed its fourth year of operation. The group support which has been given to it by Michigan doctors, despite early reverses which could easily have been fatal, now is proved justified. Moreover, Michigan Medical Service today constitutes the nation's outstanding demonstration of the practical success which can be achieved by medical service prepayment programs sponsored by the medical profession itself."

If Michigan can make a prepayment medical service plan sponsored by the medical profession operate successfully, other states, including Ohio, can do likewise.

"RURAL" MORROW COUNTY SETS THE PACE

Morrow County is one of the smaller counties of Ohio from the standpoint of population. It does have some up-and-coming industries but is usually regarded as a "rural county". This being the case, the following article from the *Morrow County Sentinel* becomes all the more significant:

"R. J. Whiting and J. Eugene Auld of the Hydraulic Press Manufacturing Company spoke Tuesday night at the monthly meeting of the Morrow County Medical Association at the RRR restaurant.

"Absenteeism and how it affected the plant and precautions taken for the protection of the health and safety of employees was the subject of an instructive talk by Mr. Whiting.

"Mr. Auld discussed the personnel problems of the plant. The doctors were taken on a tour of the plant here. Dr. F. M. Hartsock, president of the association, said that this was the first time that the medical association and industry had had such a meeting.

"'Dr. Hartsock added that more frequent meetings of this nature will give better understanding of the problems of environment in which the people of the community work and result in contributions to the health and welfare of the community."

The physicians of "rural" Morrow County are among the first to put into practice some of the recommendations of the Committee on Industrial Health of the Ohio State Medical Association. They are to be congratulated for their enterprise and foresightedness.

This should give Ohio's "industrial" counties something to think about; something to shoot at. If Morrow County finds a program of cooperation between the medical profession, employers and employes of value, certainly such a program is indicated in most of the other counties—especially those with extensive industrial activity.

IT'S TIME FOR BUSINESS AND MEDICINE TO GET TOGETHER

Mr. J. T. Meek, executive secretary of the Illinois Federation of Retail Associations, Chicago, in a recent letter to the American Medical Association, offered these observations and comments:

"There were indications from the chamber of commerce secretaries that they had had no easy time, on several occasions, interesting their members in the grave possibilities of this program (S. 1161) for the simple reason that doctors in their communities had, for the most part, been unwilling to cooperate in local chamber of commerce functions, or were completely disinterested in their local projects.

"It was clearly stated—and I have heard it repeated a number of times—that the medical profession now seeks help on something of a very serious nature from these very people for whom the profession has had little or no interest or regard." . . .

As we see it, Mr. Meek knocked out a triple in his first observation and then got caught off base in the second.

Unfortunately, too few physicians have been taking an active interest in the activities of their local chamber of commerce. The chamber of commerce is a valuable civic organization; can accomplish much good; deserves the cooperation and moral and financial support of physicians as groups and as individuals. It is to be hoped that in the future the apathy on the part of the medical profession in local groups of this kind will disappear.

However, Mr. Meek skidded when he inferred that defeat of the Wagner Bill is of greater importance to the medical profession than to business men. Who is going to foot the bills, if the Wagner Bill is enacted, may we ask? If medicine is socialized, can business escape? Should physicians be expected to be more interested in preserving free enterprise and democratic principles than business men?

If the medical profession has had to "seek"

the help of chambers of commerce in fighting the Wagner Bill, it would seem to us as if perhaps some of those organizations have been rather slow to grasp the significance of that particular proposal, especially as to how it would affect the business man.

Looks to us as if it's a stand-off. Anyway, the suggestion that two influential groups such as the chamber of commerce and the local medical society should be pulling together is a good one, so we'll excuse Brother Meek for having been caught napping in rounding third.

SALARIES FOR PHYSICIANS HOLDING STATE JOBS TOO LOW

The Governor's Committee on a Mental Hygiene Program for Ohio recently issued this significant statement to the press:

"This committee is of the opinion that the services of a qualified person to fill the position of commissioner of mental diseases cannot be secured at the present salary, and can be secured only if a salary can be offered that is comparable to the salaries paid to similar officers in states comparable to Ohio."

Even a hasty glance at the payrolls of various state departments convinces one that the same statement would apply to scads of positions which must be held by physicians. Certainly the salaries now paid physicians in the various state departments and institutions are not such as to attract very many applicants or to encourage incumbents to continue for any considerable period of time.

Ohio has just been lucky in the past to be able to get as many good physicians as it has for jobs requiring professional training. Its luck has become pretty spotty during recent years, especially under wartime conditions.

A lot of correcting of this situation is required by the State Legislature. Physicians in talking with candidates for the General Assembly would do well to bring up this point for the state with its present low-salary brackets can not complete successfully in getting men for medical assignments for work which is, in the final analysis, the business of all the people.

"DOCTOR" WALLACE ISSUES A SHOT-GUN PRESCRIPTION

Vice President Henry Wallace, in his swing around the circuit (this being election year) has been quoted by the newspapers as affirming that "health" is one of the things which "America Tomorrow" badly needs.

Said "Doctor" Wallace: "At even less cost than for clean drinking water, we can see that liberal dosages of vitamins are added to the flour and corn meal, thus wiping out at one stroke the vitamin deficiencies which undermine the health and vigor of so many of our citizens, especially those who are past 40 years of age. At a cost of $2 per year per person it would be possible to wipe out all vitamin deficiency diseases, extend the working life of the average individual 10 years, and of course, increase the vigor of at least half of our population."

Simple matter, isn't it?

Of course, few except confirmed patent medicine addicts will take "Doctor" Wallace too seriously. In fact, it would seem as if he doesn't even believe it himself (or perhaps he just got a bit confused as some Washington gents do occasionally), for he also offered these words of wisdom: "We ought to be spending four times as much on hospitals and doctors and nurses as we are now spending." If "liberal dosages of vitamins" are going to restore vim and vigor to about everybody as prescribed by "Doctor" Wallace, surely there won't be a need for more doctors, hospitals and nurses—in all probability many of them can be wrapped up in mothballs and laid on the shelf.

Sure, we can go along with "Doc" in believing that Americans need a better diet and that a better diet will minimize sickness but when it comes to advocating a return to shot-gun methods of prescribing and treatment, we'll have to pass.

P.S. Maybe "Doctor" Wallace hasn't heard about President Roosevelt's comment that maybe the New Deal label had better be forgotten.

PHYSICAL FITNESS PROGRAM NEEDS MEDICAL GUIDANCE

There recently came through the mail a news release and two beautifully printed red, white and blue booklets, announcing that the Federal Security Agency is launching a nationwide program "to curb absenteeism and other handicaps resulting from physical deficiences".

The project will be directed by a commission of 13, two of whom are physicians, and headed by President William P. Jacobs, Presbyterian College, Clinton, S. C. Chairman Jacobs announced that the program "will be taken directly to the nation's industrial executives, labor organizations and community leaders with the hope of enlisting their support in encouraging every worker to participate in regular habits and exercises.

In the commission's brochure for employers and labor organizations there is an outline of how physical fitness can be brought to every plant in the nation. The pamphlet intended for individual workers describes physical activities, exercises and body-conditioning habits. It offers advice about food, balanced relaxation, sleep, fresh air, sunshine, posture. The importance of seeing the doctor is mentioned. There is a list of agencies from which information may be obtained, including the Americal Medical Association, inserted in the booklet for industrialists.

Here is another program which will need direc-

tion and guidance by the medical profession, especially after it begins to operate in various communities. Regardless of its name, the program is fundamentally a health program and every health program needs, and should have, supervision by physicians.

Those county medical societies which have not shown an interest in starting an Industrial Health Program and those societies which have failed to establish a committee on Physical Fitness and Recreation had better do some deep thinking. Now is the time for all county societies to get ready for responsibilities which are going to have to be taken on when, and if, this or similar projects are launched in local areas, or, better yet, to initiate programs of their own immediately.

A. F. OF L. EXPRESSES ITSELF ON BUREAUCRATIC DOMINATION

"Do we want a great bureaucracy to dominate American life after the war, with dictators like those we now have who can set aside collective bargaining agreements without even considering the facts on which these agreements are based? Do we want to be ruled by individuals from whose decisions there is no appeal? Do we want domination by the military? This is the Fascist way, not the American way. Yet the surest way to get this very dictatorship is to fail now to set up a democratic civilian agency to direct post war policy, with assured representation of all groups concerned."

The above quotation was not culled from the publications of the United States Chamber of Commerce, the National Manufacturers' Association or the American Medical Association.

The original will be found in *Labor's Monthly Survey*, Vol. 5, No. 2, 1944, page one, publication of the American Federation of Labor.

If that is the policy of the A. F. of L. and the A. F. of L. actually means what that statement says, it can not, even by a stretch of the imagination, be for the Wagner Bill or similar proposals. Put the government in charge of medical and health programs, big or little, and you have a bureaucracy, big or little, dominating American life in one degree or another. If domination is bad in the field of labor-employer relations, it is bad also in any other field of human relations.

AUXILIARY OFFERS SOME ADVICE WHICH RINGS THE BELL

In concluding its annual report, published recently in the *Cleveland Academy of Medicine Bulletin*, the Legislative Committee of the Cleveland Academy Woman's Auxiliary made this significant observation:

"The Legislative Committee, in studying the numerous Bills introduced into Federal and State Legislatures, is convinced of the ease with which a Bill can be directed into channels which might change the whole future of medicine. Worthy of note that, during the last regular session of the Ohio General Assembly, although there were no laws enacted injurious to public health and medical practice, there was an alarming amount of support given to various socialized measures, cult, and limited practice groups who seek to undermine the Medical Practice Act. This again demonstrates a valuable lesson: the time to exert efforts to stop the spread of govermental medicine is while proposed legislation is pending and before the measure is enacted into law. Therefore, we cannot stress too forcefully the care that should be exercised in the selection of candidates to the General Assembly. Keep abreast of proposed medical legislation through *The Journal of the American Medical Association* and *The Ohio State Medical Journal*, and voice your protests to the Senators and Representatives. In this momentous debate there can be no disinterested onlooker. Do your part to preserve the practice of medicine under the American system which has developed the most effective medical care in the world."

That, Doctor, is good advice. What we should say is that this is some more good advice for you from the "Mrs".

OFFICE HOUSECLEANING WILL HELP THE PAPER SALVAGE CAMPAIGN

Cooperation of hospitals, physicians, and dentists in the waste paper salvage campaign has been asked by the War Production Board. A physician may ask, "How in the heck can I help in this program?". Facetiously, one might reply that this would be a good way for him to get rid of those nine-month old magazines he has on his reception room table. Seriously, however, we feel each physician can be of assistance by disposing of old books, magazines, newspapers and obsolete records which are in his office and by saving for the salvage agencies wrappings, cartons, advertising literature and bulletins. Also, such items as old ledgers, correspondence, receipts, canceled checks, invoices, calendars, and catalogs are sources of waste paper.

It has been estimated that 100 pounds of paper will make 200 containers for blood plasma or 1,470 cartons for emergency lifeboat rations or 17 protective bands for 500 pound bombs or 650 cartons for field "K" ration or 1,110 cartons for incendiary bullets or 300 containers each containing one tube of poison gas ointment or 100 cartons each containing 10 dozen fever vaccine.

Better check your office, ferret out the old paper and dispose of it immediately through regularly established waste paper dealers. If one is not available, call your WPB office for advice. The paper shortage is critical and you can help in meeting the crisis. Also, an office housecleaning will be good for your morale.

Interesting Data on Hospitals Found in Newest Report of A.M.A. Council; Figures on Ohio Institutions

THE Twenty-Third Annual Presentation of Hospital Data by the Council on Medical Education and Hospitals of the American Medical Association, for the year 1943, as published in the March 25, 1944, issue of *The Journal of the AMA*, contains a wealth of statistical information and interesting observations on hospital service and medical education in the United States.

In an editorial summarizing the report, *The Journal* said:

"In war as in peace, the hospitals of the United States continue to render faithful and efficient service to the sick and injured of the nation. The tremendous task they assume under wartime conditions is illustrated in the annual hospital report. . . . The number of patients admitted in 1943 reached the unprecedented total of 15,374,698, as compared with 12,545,610 in 1942. In addition, there were 1,924,591 hospital births, an increase of 253,992 over the previous year. Similarly the daily patient load or average census increased by 131,096, not counting newborn infants. Equally impressive is the expansion of hospital beds from 1,383,827 in 1942 to 1,649,254 in 1943. This increase of 265,427 beds is the equivalent of a new 727 bed hospital for each day of the year. When this recent growth is compared with the average annual increase of 25,000 to 30,000 beds in the twenty year period that preceded the war, the extent to which hospital facilities have been developed in relation to wartime needs may be better appreciated.

GAIN IN FEDERAL GROUP

"The greatest gain has naturally occurred in the federal group, whose admissions increased by 2,356,885 in the last year. Significantly the state, county and municipal hospitals showed a decrease of 103,733, while the nongovernmental group comprising the church related institutions, other nonprofit associations and the proprietary hospitals had a substantial increase of 575,936.

"Although several factors may be involved, the influence of improved economic conditions is clearly evident in the changes that have occurred in the non-federal hospital groups. The general hospitals constitute the largest division in the classification of hospitals according to type of service. They have 51 per cent of the bed capacity but received 94 per cent of all patients admitted in 1943. Their participation in the recent expansion of hospital service can be measured by an increase of 2,820,350 admissions during the year.

AVERAGE LENGTH OF STAY

"The average length of stay in the general hospitals was identical with that reported in 1942 except in the federal, state and city-county groups, which showed reductions of one to two days. The average in the governmental hospitals, however, remained at 19 days as in the previous year because of the large increase of patients in the federal group, in which the longest stay occurred. In the nongovernmental general hospitals the patients had an average stay of ten days. There was a decrease in the percentage of bed occupancy in the federal and general hospitals. This reduction in the face of a greatly increased admission rate is primarily the result of a rapid expansion of federal hospital facilities in anticipation of future needs. The occupancy rate in these institutions therefore has not kept pace with the number of beds available for hospital care. . . .

ALMOST ALL REPORTED

"Attention is called to the extraordinary completeness of the present report in relation both to civilian and to military hospitals. Information as required for tabulation purposes and the hospital list was received from nearly 99 per cent of the 6,655 hospitals now registered by the American Medical Association. For reasons of military security many of the newly established hospitals in the federal group are not listed in the Register; they are, however, included in the tabular and statistical data published by the Council. Grateful acknowledgment and appreciation are extended to all who cooperated in making this report possible. The hospitals which supplied information to the Council have also been of service to the country at large, for the annual hospital reports of the American Medical Association have become increasingly valuable in relation to wartime needs and are widely utilized by federal agencies, civilian groups and individuals concerned with hospital activities and allied services.

EXCELLENT JOB DONE

"Many of the hospitals have rendered increased service while operating with reduced staffs of physicians, house officers, nurses, technicians and general and special service personnel. Their accomplishment in the face of these difficulties reflects not only a high degree of standardization but also the initiative, pride of occupation, loyal cooperation and devotion of those who serve the sick. By careful administrative management, coordination of services and skillful utilization of available facilities and personnel the increased demands of the wartime period have been met."

The hospital report lists 6,655 registered hospitals, a net increase of 310 over 1942. The largest gain occurred in the federal group which



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now consists of 827 hospitals as compared with 474 in 1942. The other governmental groups—state, county, city-county—gained 7 hospitals and the nonprofit organizations 30. The number of proprietary hospitals was reduced by 80.

INCREASE IN ADMISSIONS

The number of admissions in registered hospitals represented an increase of 22.5 per cent over 1942. Ninety-four per cent of all patients admitted to the registered hospitals in 1943 were admitted to general hospitals.

Patients entered hospitals in the United States last year at the rate of one person every two seconds. In the same annual period 11.6 per cent of the entire population of the United States, on the basis of the 1940 census, received inpatient hospital care.

Of considerable importance is a new feature in the hospital report containing the results of a study of hospital facilities for contagious diseases. It reveals that 1,649 hospitals provide 39,282 beds for this purpose. These facilities are in addition to 8,313 beds available in 55 isolation hospitals. The number of hospitals devoted to the care and treatment of contagious diseases has decreased from 98 in 1927 to 55 at the present time. There has also been a decrease in bed capacity during this same period. However, the number of beds shows an increase of 2,034 in comparison with 1942. Admissions have varied from 30,279 in 1939 to 49,570 in 1943, the latter representing a gain of 11,634 over 1942.

Speaking of isolation facilities the report says that "It is recognized, of course, that isolation hospitals do not furnish all the facilities required for the segregation and care of contagious diseases throughout the country. Many other hospitals maintain units for isolation care or temporary hospitalization of patients awaiting transfer to other contagious disease departments. . . . Tuberculosis facilities were not included in this study. . . ."

ADDITIONS TO REGISTER

During the last year 456 new institutions were admitted to the Hospital Register, whereas 146 were closed or transferred to the unclassified file. The report says that at the present there are seventy-six applications pending in regard to hospital registration.

There is a group of 523 hospitals which, according to information received, do not maintain a service in accordance with the requirements outlined in the general standards of the Council. These hospitals have only 15,215 beds, or less than 1 per cent of the total capacity of all hospitals. It is also pointed out in the report that certain other facilities are also omitted from the Register, namely, clinics, emergency stations, offices, and so on, where bed care may be available as occasions demand. Many of these unclassified units constitute valuable auxiliary facilities in a community, even though their capacity may be limited to only a few beds.

SOME HOSPITALS CLOSED

The report explains that a net loss of 80 hospitals in the proprietary group may in part at least be accounted for by such institutions discontinuing their service because they were small and apparently had difficulty in securing sufficient personnel. In some instances the closing of individually owned hospitals became necessary when the physician in charge left to enter military service.

Of particular significance is the revelation in the report that more than 96 per cent of the births reported in 1943 were in general hospitals, while 3.4 per cent occurred in maternity hospitals. It is also pointed out that the nongovernmental hospitals had 85 per cent of the births while the governmental group had 15 per cent.

COMMENTS ON 9-9-9 PROGRAM

The report of the Council includes a section on "'Internships and Residencies". Following are some of the comments in that section concerning the 9-9-9 program:

"On Jan. 1, 1944, when the 9-9-9 program of the Procurement and Assignment Service was inaugurated, there were 715 civilian hospitals approved for internships and 659 for residency training. The total number of approved hospitals, however, was 1,054, since 320 were accredited in both classifications. The federal hospitals approved by the Council for intern and residency training are not included in the present study.

"Reports received at the beginning of the year showed that the approved hospitals had 5,170 interns on duty, 1,452 assistant residents and 2,064 resident physicians. These figures, it should be noted, are considerably lower than those reported in January, 1943, when 5,567 interns were employed, 1,210 assistant residents, 2,633 resident physicians and 609 fellows. The present distribution of interns and residents, by states, is shown in the accompanying table.

"A separate article describing the present status of the 9-9-9 program is included in this report. On purely educational grounds it would be impossible to defend a nine month internship, which must be regarded as a wartime educational casualty. Reluctantly, and only after careful consideration of the advantages and disadvantages and weighing the possible alternatives, the Council has recognized the so-called 9-9-9 plan as the best available under present wartime conditions.

MANPOWER CONSERVED

"The plan conserves medical manpower for both military and civilian use. Each year approximately 7,000 men graduate from medical schools under the accelerated program. Under



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the old plan, three months of their internship would overlap with the internships of the next class. The quality of instruction in the overlapping period was often inferior, adding considerably less than the equivalent of three months' time to the nine month overlapping period.

"The 9-9-9 program assures the deferment of assistant residents and residents, even though the period of additional training is less than the three or more years generally considered desirable, and readily attainable in peacetime. It was the only method of deferment of commissioned officers as assistant residents and residents on which agreement could be reached. If a one year internship was to be continued, hospitals would be forced to operate without any commissioned officers deferred as residents. It is better to have one-third of the intern group continue for nine months as assistant residents and one-sixth of the group for a second nine months as residents than to have no deferments for hospital service after the first year of internship. The latter was apparently the only alternative and was considered to be less desirable than the 9-9-9 program.

TYPES OF INTERNSHIP

"The internship has long been considered an essential preparation for general practice and a prerequisite for subsequent specialty training. It now holds a similar relationship to the needs of the military service and should therefore be organized in such a manner that interns will receive wide experience in the major divisions of medicine and a thorough training in modern medical technics. To accomplish this purpose most hospitals are offering a rotating type of service, as evidenced by recent reports. These indicate that 673, or 94 per cent, of the approved internships are of the rotating type, while only 23, or 3 per cent, are mixed and 19, or 2 per cent, straight. Ten hospitals have combined services, such as rotating and straight or straight and mixed.

"In relation to individual internships, it can be shown that 4,551 interns, or 88 per cent of the total number, are now serving on a rotating basis and 152, or 3 per cent, are in the mixed group, while 467, or 9 per cent, have straight assignments. In 1942 the corresponding figures were 86.2, 3.2 and 10.5 respectively."

DATA ON OHIO HOSPITALS

The Council registered 236 Ohio hospitals in 1943, six less than in 1942. Their bed capacity was 59,616; bassinets, 3,608, as compared with 58,532 and 3,351 respectively, in 1942. Patients admitted totaled 626,184, a considerable increase over 1942, when 583,491 patients were admitted. The average daily census was 51,384, slightly less than the 1942 figure of 52,537.

Ohio hospitals are classified by control as follows: Federal, 9; state, 23; county, 26; city, 20; church, 43; nonprofit associations, 95; individual and partnership, 11; corporations, 9—a total of 235, of which 158 are nongovernmental.

Classification of Ohio's registered hospitals by type of service is as follows: General, 150; nervous and mental, 24; tuberculosis, 22; maternity, 7; industrial, 1; children's, 3; orthopedic, 3; isolation, 1; convalescent and rest, 7; hospital departments of institutions, 16; others, 2.

HOSPITAL PERSONNEL

The report shows that in 1943 the administrator or superintendent of 73 of Ohio's 236 registered hospitals was an M.D.; 74, an R.N., and 89, "other". There were 67 accredited schools of nursing, with 6,667 student nurses. Other nursing personnel included: graduate nurses employed at nursing, 4,755; other graduate nurses, 920; practical nurses, 592; nurses' aides, 2,043; attendants, 2,583; and orderlies, 591. Technical personnel included: laboratory technicians, 456 full time and 103 part time; X-Ray technicians, 256 full time and 61 part time; dietitians, 286 full time and 39 part time; physical therapists, 102 full time and 26 part time; pharmacists, 108 full time and 23 part time; medical record librarians, 141 full time and 41 part time; other librarians, 40 full time and 23 part time; medical stenographers, 239 full time and 51 part time; occupational therapists, 63 full time and 10 part time; dental hygienists, 24 full time and 38 part time; social service workers, 119 full time and 27 part time; nurse anesthetists, 122 full time and 4 part time.

HOUSE STAFF FIGURES

According to the report, the total number of house staff members on duty in Ohio's 56 approved hospitals on January 1, 1944, was as follows: Interns, 245; assistant residents, 127; residents, 118. Comparable totals for January, 1943, were: Interns, 305; assistant residents, 118; residents, 125.

APPROVED FOR INTERNSHIP

The following Ohio hospitals, numbering 41, are approved for internship: City, Peoples and St. Thomas Hospitals, Akron; Aultman and Mercy Hospitals, Canton; Bethesda, Christ, Cincinnati General, Deaconess, Good Samaritan, Jewish and St. Mary's Hospitals, Cincinnati; City, Cleveland Clinic Foundation, Fairview Park, Lutheran, Mt. Sinai, St. Alexis, St. Luke's, St. Vincent's Charity, and University Hospitals; Cleveland; Grant, Mt. Carmel, St. Francis, Starling Loving University and White Cross Hospitals, Columbus; Huron Road Hospital, East Cleveland; Good Samaritan, Miami Valley and St. Elizabeth's Hospitals, Dayton; Memorial and St. Rita's Hospitals, Lima; City Hospital, Springfield; Lucas County, Mercy, St. Vincent's, Toledo Hospitals, and Women's and Children's, Toledo;

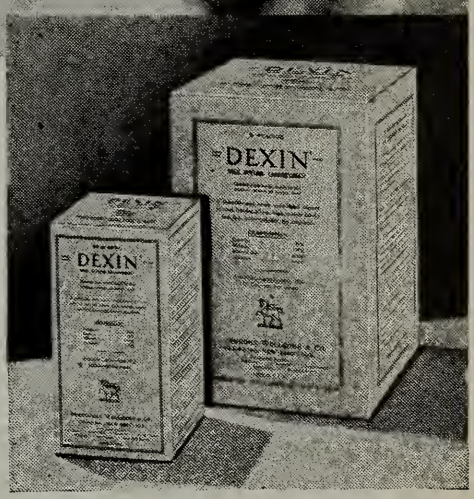


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Youngstown and St. Elizabeth's Hospitals, Youngstown.

APPROVED FOR RESIDENCIES

Hospitals in Ohio approved for residencies in specialties number 43. They are: Children's, People's, City and St. Thomas Hospitals, Akron; Mercy Hospital, Canton; Christ, Children's, Cincinnati General, Deaconess, Good Samaritan, Hamilton County Tuberculosis, Jewish, Longview State Hospitals, Cincinnati; City, Cleveland Clinic Foundation, Fairview Park, Glenville, Grace, Mt. Sinai, St. Alexis, St. John's, St. Luke's, St. Vincent's Charity, and University Hospitals, Cleveland; Children's, Columbus State, Mt. Carmel, Starling Loving University, St. Francis, Franklin County Tuberculosis, Grant and White Cross Hospitals, Columbus; Miami Valley Hospital, Dayton; Huron Road Hospital, East Cleveland; Mercy Hospital, Hamilton; General Hospital, Mansfield; Massillon State Hospital, Massillon; Lucas County General, and St. Vincent's Hospitals, Toledo; Cleveland Tuberculosis Sanatorium. Warrensville; Harding Sanitarium, Worthington; and St. Elizabeth's and Youngsownt Hospital, Youngstown.

PATHOLOGICAL TRAINING

The report of the Council contains a list of 227 schools approved for training clinical laboratory technicians. The list includes the following in Ohio: City Hospital, Akron; St. Thomas Hospital, Akron; Good Samaritan Hospital, Cincinnati; Mt. Sinai Hospital, Cleveland; University Hospitals, Cleveland; Mt. Carmel Hospital, Columbus; Starling Loving University Hospital, Columbus; Huron Road Hospital, East Cleveland; Mercy Hospital, Toledo; Toledo Hospital, Toledo; St. Vincent's Hospital, Toledo; Youngstown Hospital, Youngstown.

The Cleveland Clinic Foundation Hospital, Cleveland, is included in the 28 schools approved in the United States for the training of physical therapy technicians.

Ohio State University, Columbus, is one of the 13 schools in the country approved for the training of occupational therapy technicians.

Sanitarium Elects New President

E. Elliott Otte has been elected president of the Cincinnati Sanitarium to succeed the late Harry P. Collins, who served as president of the medical institution for 38 years. For the last 15 years Otte has been vice-president of the sanitarium. Other officers are Miss Katherine C. Martin, vice-president; Mrs. June Otte, treasurer, and Miss Harriet W. Collins, secretary. Reappointed were Dr. Douglas A. Johnston as medical director; Dr. Wilford N. Wright as resident physician, and Dr. Emerson A. North and Dr. Charles E. Kiely as consultants.

Plan For Financial Assistance In Relocating Physicians Adopted

In enacting Public Law No. 216, the Congress appropriated $200,000 for the United States Public Health Service to be used in assisting the relocation of physicians in areas needing private practicing physicians and dentists.

Major provisions of the act are as follows:

1. That a municipality, county or other local subdivision of government may submit an application to the Surgeon General for the relocation of a private practicing physician or dentist in the applicant subdivision.

2. That such application must be duly approved by the State Health Department having jurisdiction over said municipality, county or other local subdivision of government.

3. That the Surgeon General on receiving such application is authorized to enter into an agreement with a private practicing physician or dentist under which, in consideration of a relocation allowance of not to exceed $250 per month for three months and the actual cost of travel and transportation of the physician or dentist and his family and household effects to the new location, such physician or dentist agrees to move to and engage in the practice of his profession in the applicant subdivision for a period of not less than one year.

4. That no such contract shall be made with any physician or dentist unless such physician or dentist shall be admitted to practice by the state authority having jurisdiction of such new location.

5. That each such applicant subdivision shall contribute 25 per centum to the total cost of such relocation allowance, travel and transportation costs of each such physician or dentist and his family obtained by such applicant.

Any application must be approved by the state director of health. He and the Procurement and Assignment Service chairman of the state are expected to cooperate in determining which communities are in need of physicians and dentists. The Procurement and Assignment chairman is responsible for determining which physicians (or dentists) are available for relocation.

Cincinnati—Dr. Clarence A. Mills, professor of experimental medicine, University of Cincinnati, spoke on "Climate and Weather Influences on Dietary Needs", at a meeting of the Cincinnati Dietetic Association.

Fremont—Staff officers of Memorial Hospital are: Dr. A. F. Schultz, chief; Dr. C. I. Kuntz, vice-president; and Dr. E. C. Swint, secretary.

Toledo—Dr. Thomas F. Heatley has been appointed to fill the vacancy on the local Board of Health caused by the resignation of Dr. Edward J. McCormick.

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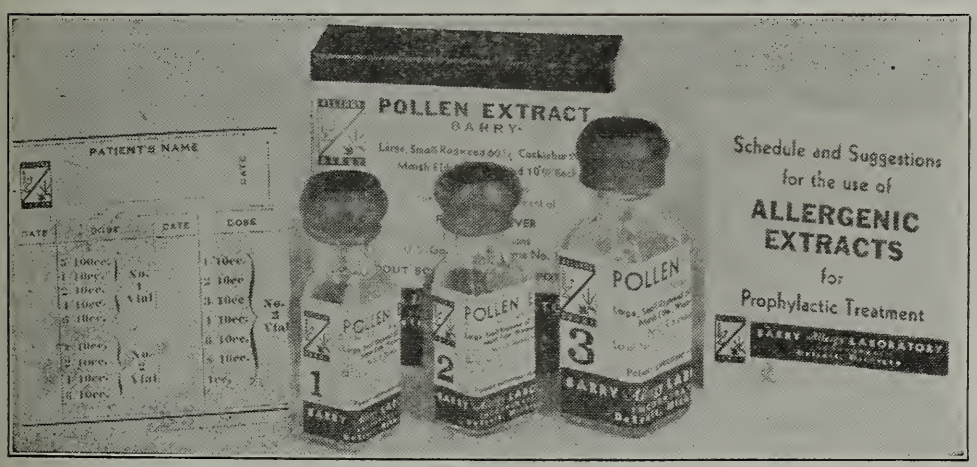
Barry Allergy Laboratories have carried on specialized surveys and research, extending over a decade, to determine the allergenic pollens most prevalent in your state at various seasons of the year. Pollen counts and analytic field studies enable us to place at your disposal a group of STOCK TREATMENT SETS that present the following advantages: (a) 3-vial set requiring no diluting or mixing; (b) ready for instant use; (c) flexibility of dosage.



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The three vials furnished contain the following: 100 units/cc., 1,000 units/cc., and 10,000 units/cc.

A special vial is also available (30,000 units/cc.) for perennial treatment throughout the year, or where higher dosage is indicated.

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In Memoriam

Calvin Bates, M.D., Cambridge; Miami Medical College, 1886; aged 88; died March 28. Probably the oldest practicing physician in Southeastern Ohio, Dr. Bates was located in Lore City and Senecaville for a number of years, moving to Cambridge in 1911. He was Guernsey County coroner several terms. He was a member of the Presbyterian Church. A daughter and a son survive.

Thomas Armer Burneson, M.D., Lisbon; Hahnemann Medical College of Philadelphia, 1897; aged 83; died March 24. Dr. Burneson practiced in Lisbon for over 40 years. Two daughters and two sisters survive.

William E. Clough, M.D., Oxford; Eclectic Medical College, 1892; aged 78; died March 21. Dr. Clough retired from the practice of medicine many years ago. He managed a local drug store for several years. Dr. Clough recently received the 50-year insignia of the Masonic Order.

Byron Danford, M.D., Athens; University of Cincinnati College of Medicine, 1924; aged 45; member of the Ohio State Medical Association and Fellow of the American Medical Association; died March 1, following an automobile accident. Dr. Danford had practiced in Athens for 19 years. He was a former president of the Athens County Medical Society, and delegate from the society to the State Association in 1943. Dr. Danford was a veteran of World War I, a member of the American Legion, Elks, Eagles, Rotary Club, Phi Delta Theta and Nu Sigma Nu. His widow, his mother and five sisters survive.

Frank Adams Ewers, M.D., Akron; Jefferson Medical College of Philadelphia, 1905; aged 66; member of the Ohio State Medical Association and the American Medical Association; died March 9. Dr. Ewers practiced in Akron for nearly 40 years. Surviving are his widow, a son, a daughter, and a brother.

Jesse Bernard Francis, M.D., Troy; Hahnemann Medical College and Hospital, Chicago, 1908; aged 64; former member of the Ohio State Medical Association and the American Medical Association; died March 21, at Asheville, N.C. Dr. Francis practiced in Troy for many years, retiring several years ago because of failing health. He was a 1st lieutenant in the Medical Corps of the U.S. Army in World War I. Dr. Francis was a member of the Eagles, Masonic Lodge and the Methodist Church. Three sons survive.

Nathan Hill, M.D., Nelsonville; College of Medicine and Surgery, Chicago, 1891; aged 77; member of the Ohio State Medical Association and the American Medical Association; died March 23. A former mayor of Nelsonville, Dr. Hill practiced there for 53 years. He had served as coroner of Athens County and member of the local board of education. Dr. Hill was a member of the Knights of Pythias and the Presbyterian Church. Two sisters survive.

Edward Victor Hug, M.D., Lorain; Jefferson Medical College of Philadelphia, 1893; aged 75; former member of the Ohio State Medical Association and the American Medical Association; died April 15. Retired for several years, Dr. Hug practiced in Lorain for over 40 years. He was a former president of the Lorain County Medical Society, and a former health commissioner of the county. His widow, a daughter and a son survive.

Fannie Collins Hutchins, M.D., Cleveland; University of Southern California School of Medicine, Los Angeles, 1893; aged 78; member of the Ohio State Medical Association and Fellow of the American Medical Association; died March 13. One of Cleveland's first women physicians, Dr. Hutchins practiced there for nearly 50 years. She was a member of the staff of Woman's Hospital. Two brothers survive.

Robert John Judkins, M.D., Bainbridge; University of Cincinnati College of Medicine, 1912; aged 57; former member of the Ohio State Medical Association and the American Medical Association; died March 19. Dr. Judkins served in the Royal Army Medical Corps of the British Army and the Medical Corps of the U.S. Army during World War I. After the war, he practiced in Wilmington for a short time, later in Cincinnati and Hillsboro, retiring a number of years ago because of ill health. He is survived by his widow, two daughters and two sons.

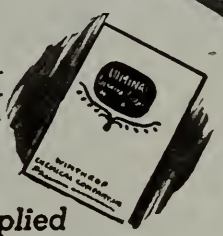
Isaac W. Keenan, M.D., Fort Myers, Fla.; Jefferson Medical College of Philadelphia, 1895; aged 76; former member of the Ohio State Medical Association and the American Medical Association; died March 15. Dr. Keenan first practiced in Piedmont, Harrison County, locating in Quaker City in 1899. He established a hospital there, and in 1906 moved the hospital to Cambridge. Dr. Keenan had resided in Florida for several years. Surviving are his widow, three sons and three sisters.

George Davis Lowry, M.D., Detroit; Columbia University College of Physicians and Surgeons, 1894; former member of the Ohio State Medical Association and Fellow of the American Medical Association; died April 9, following an automobile accident near Toledo, in which his wife also was killed. The son of Methodist missionaries, Dr. Lowry was born in Foo Chow, China. After completing his education, he taught for several

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years at the Pekin Union Medical School, and for 31 years was superintendent of the Pekin Methodist Hospital. Returning to Cleveland in 1925, he practiced there for two years, and was then called to Ohio Wesleyan University, Delaware, to establish a student health service. He later entered private practice in Delaware and at the time of his death was practicing in Detroit. Eight children survive.

James A. McCollam, M.D., Uhrichsville; Starling Medical College, 1890; aged 76; member of the Ohio State Medical Association and the American Medical Association; died March 13. The oldest practicing physician in Tuscarawas County, Dr. McCollam had been active in the professional and civic life of his community for over 50 years. A former president of the county medical society, he had been its legislative committeeman since 1918. Dr. McCollam was Uhrichsville's first health commissioner, founder and a past-president of the High School library association; served several terms as president of the local board of trade, and was vice-president of the Buckeye Club at the time of his death. For more than 40 years he was an elder in the Christian Church. Surviving are his widow, five daughters and two sons, one of whom, Dr. Ben McCollam, practices in Toledo.

Charles Madison Mooney, M.D., Columbus; University of Michigan Medical School, Ann Arbor, 1900; aged 73; died March 24. Dr. Mooney retired two years ago after having practiced in Columbus for 20 years and previously in Waverly. He was a member of the Masonic Order and the Presbyterian Church. His widow, a daughter, two sons, a sister and three brothers survive.

John Richard Moore, M.D., Xenia; Eclectic Medical College, Cincinnati, 1906; aged 68; member of the Ohio State Medical Association and the American Medical Association; died March 29. A graduate of Wilberforce University, Dr. Moore first practiced in Anderson, Ind., and after nine years in Zanesville, located in Xenia in 1918. His widow, three sisters and three brothers survive.

Clark Edwards Sharp, M.D., Columbus; Starling Medical College, Columbus, 1896; aged 70; member of the Ohio State Medical Association and the American Medical Association; died April 3. Dr. Sharp practiced in Columbus for 48 years. He was a captain in the Medical Corps of the U.S. Army during World War I, serving for over a yera at Base Hospital 64, near Verdun, France. Dr. Sharp was a member of the Methodist Church, Masonic Order and the American Legion. Surviving are his widow, two daughters, three sons—all physicians, Dr. Jay E., Zanesville; Dr. Robin T., Columbus; Dr. Martin C., Detroit; and a sister.

Oliver Thoroman Sproull, M.D., West Union College of Physicians and Surgeons, Baltimore, 1886; aged 81; member of the Ohio State Medical Association and Fellow of the American Medical Association; died March 8. A life-long resident of Adams County, Dr. Sproull had practiced there for 58 years. One of the real wheelhorses of medical organization in Ohio, Dr. Sproull was secretary of the county medical society for many years, and was a regular participant in the district and state medical meetings. Active also in community affairs, he was a charter member of the West Union Lions Club; president of the Adams County Building and Loan Co.; director of the Defender Publishing Company and a charter member of the local American Legion Post. During World War I, Dr. Sproull was a captain in the Medical Corps of the U.S. Army. Surviving are a son, and two daughters, one of whom is Dr. Hazel Sproull, practicing in West Union.

George Seeley Smith, M.D., Cleveland; Harvard Medical School, Boston, 1893; aged 77; member of the Ohio State Medical Association and Fellow of the American Medical Association; died April 1. Dr. Smith retired in 1940, after practicing in Cleveland for over 40 years. He was a member of the Episcopal Church. Surviving are his widow, two sons and a brother.

Wade Walton Stone, M.D., Toledo; University of Michigan Medical School, Ann Arbor, 1922; aged 46; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; died March 27. Dr. Stone practiced in Toledo for over 20 years. He was a member of the Episcopalian Church, Theta Delta Chi and Nu Sigma Nu fraternities. Surviving are his widow, a daughter, a son and a sister.

John A. Thompson, M.D., Brookville, Ind.; Miami Medical College, Cincinnati, 1884; aged 85; former member of the Ohio State Medical Association; former Fellow of the American Medical Association, American College of Surgeons and the American Laryngological, Rhinological and Otological Society. Professor-emeritus of laryngology at the University of Cincinnati College of Medicine, Dr. Thompson was on the staff of Christ and General Hospitals for many years prior to his retirement in 1922. Two daughters and a son survive.

Recent Marriages

Recent marriages of Ohio physicians include the following: Miss Leona V. Webster and Dr. Fred S. Basquin, both of Chardon; Miss Laura Vial of La Grange, Illinois, and Lt. (j.g.) Jos. M. Ryan, MC USNR, Cleveland; Miss Helen Lucile Beals, Summit Station, and Dr. Fred G. Schlecht, Youngstown.



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1. Kerr, W. H. et al.: Nebr. State Med. J., 26:129, 1941.

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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

A meeting of the Adams County Medical Society was held at the Court House, West Union, April 19, beginning at 10:30 A.M. Following a business session, Mrs. LaRue Henderson, Manchester, spoke on "The Women's Field Army for the Control of Cancer". Members of the society presented interesting case histories. After dinner, at which the West Union members were hosts to their colleagues, Dr. Leo H. Reisenbeck, Cincinnati, discussed "Some Ear, Nose and Throat Problems as Related to General Practice", and Dr. Ralph W. Eddy, Cincinnati, discussed "Uterine Hemorrhage".—H. L. Sproull, M.D., secretary.

BUTLER

Dr. Jerome Ziegler, medical advisor to the Cincinnati Hospital Care Corporation, gave a report on recent conferences between Blue Cross plan executives and proponents of the Wagner Bill, and Major Paul N. Ivins, Hamilton, spoke on "Military Medicine in the Southwest Pacific", at a meeting of the Butler County Medical Society, March 23, at Fort Hamilton Hospital, Hamilton. Major Ivins is now at Camp Breckenridge, Ky., after two years in Australia and New Guinea.

The society held a joint meeting with the Mercy Hospital staff at Middletown, April 20. Two cases of meningitis were presented by members of the staff. Four members of the society who graduated in 1894 were honored on their Golden Anniversaries. They are: Dr. R. Harvey Cook, Oxford; Dr. J. B. Grothaus, Hamilton; Dr. Wm. T. Shipe, Middletown, and Dr. O. J. Smith, Ross. Dr. Grothaus presented a paper on "Meniere's Disease", and talks were made by Drs. Smith and Cook.—Azel Ames, Jr., M.D., president.

CLINTON

Dr. W. L. Wead, Sabina, spoke on "Hematuria", at a meeting of the Clinton County Medical Society, March 7, at the General Denver Hotel, Wilmington.

"Fungus Diseases of the Skin", was the topic discussed by Dr. L. H. Fullerton, New Vienna, at a meeting of the society, April 4.—R. W. DeCrow, M.D., secretary.

HAMILTON

The following programs were presented by The Academy of Medicine of Cincinnati during April:

April 4—Hospital Night, arranged by the Department of Internal Medicine, Cincinnati General Hospital. "Sacroidosis", Dr. Harry Siegel; "Sulfa-Drug Toxicity", Dr. Carl Vilter; "Refractory Anemia", Dr. Robert M. Woolford; "Psychosomatic Factors in Bronchial Asthma", Dr. Milton Rosenbaum; "Hyperinsulinism", Dr. Vinton E. Siler.

April 18—Auspices of The Cincinnati Dental Society. "The Mouth as a Barometer of Health", Fred D. Miller, D.D.S., Altoona, Pa.—Bulletin.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

MIAMI

Dr. H. R. Pearson, West Milton, read a paper entitled "Fifty Years of Medical Practice in Retrospect", at a meeting of the Miami County Medical Society held in his honor at the West Milton Inn, April 7. Dr. Pearson has practiced at West Milton, in the same location, since March, 1894.—G. A. Woodhouse, M.D., secretary.

MONTGOMERY

Members of the Montgomery County Medical Society were guests of the medical staff at the Veterans Administration Facility, Dayton, April 7. The following program was presented: "Progress in the Diagnosis and Treatment of Malignancy", Lt. Col. C. C. Burton; "Progress in the Diagnosis and Treatment of Pulmonary Tuberculosis", Lt. Col. B. A. Cockrell; "Resume of Pathological Material, 1943", Major W. M. Abramson.

Dr. S. H. Ashmun is chairman of the Preschool Round Up, set for April 19.—C. D. Padan, M.D., president.

Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

ALLEN

A motion picture, "Abdominal Complete Hysterectomy of Fibroids", was shown at a meeting of the Lima and Allen County Academy of Medicine, March 21, at the Lima Memorial Hospital.—C. Badertscher, M.D., secretary.

MARION

Dr. Dana W. Cox, Columbus, gave an address on "Obstetrics" at a meeting of the Marion County Academy of Medicine, March 2, at the Marion City Hospital.—News clipping.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

LUCAS

The Academy of Medicine of Toledo presented the following programs during April:

April 7—General Meeting. "Hypertension", Dr. Chauncey C. Maher, chief, Department of Medicine, Cook County Hospital, Chicago.

April 14—Section of Pathology, Experimental Medicine and Bacteriology. "Conditions Associated With Leukopenia", Dr. Frank Bethell, as-

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2—149-154.

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sistant professor of internal medicine, University of Michigan Medical School, Ann Arbor.

April 21—Medical Section. "Paroxysmal Rapid Heart Action—Diagnosis and Management", Dr. F. F. Rosenbaum, assistant professor of internal medicine, University of Michigan Medical School, Ann Arbor.

April 28—Surgical Section. "Symposium on Anesthesia", Dr. H. H. Stevens, discussion leader; Drs. A. A. Brindley, S. J. Coulter, J. P. Fakehaney and H. G. Pamment, discussants.—Bulletin.

PUTNAM

Dr. Ira D. Baxter, Lima, gave a very practical talk on "Surgical Problems of Interest to the General Practitioner", at a meeting of the Putnam County Medical Society, March 7, at the Court House, Ottawa.

"Heart Ailments of Childhood and Early Adolescence", was the topic ably discussed by Dr. F. G. Maurer, Lima, at a meeting of the society, April 4.—J. R. Echelbarger, M.D., secretary.

Fifth District

(COUNCILOR: E. P. McNAMEE, M.D., CLEVELAND)

CUYAHOGA

The Academy of Medicine of Cleveland presented the following programs during April:

April 14—Joint Meeting of the Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine. Experimental Studies in Fluid, Electrolyte and Nitrogen Balance, from the Departments of Surgery and Bio-Chemistry, Western Reserve University. "Starvation in Clinical Surgery", Dr. C. H. Lenhart; "Plasma Volume, 'Available (Thiocyanate) Fluid' and Total Circulating Plasma Proteins in Normal Persons", Grace Griffin, B.S.; "Body Fluids and Plasma Protein Changes in Normal and Hypoproteinemic Dogs Following a Single Non-fatal Hemorrhage", Dr. M. P. Pride; "A Comparison of 'Amigen' and Dried Beef Serum in Restoring Plasma Albumin in the Hypoproteinemic Dog", C. A. Kuether, Ph.D.; "Oral and Jejunal Administration of Bovine Serum for Correction and Prevention of Hypoproteinemia in Surgical Patients", Dr. F. R. Mautz.

April 21—General Meeting. "The Recognition and Treatment of the Convulsive State", Dr. Tracy Putnam, professor of neurology and neurosurgery, Columbia University College of Physicians and Surgeons.—Bulletin.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

SUMMIT

"Diagnosis and Treatment of Common Abdominal Diseases", was the topic discussed by Dr. Henry K. Ransom, professor of surgery, University of Michigan Medical School, Ann Arbor, at a meeting of the Summit County Medical Society, April 4, at City Hospital, Akron.—Bulletin.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

TUSCARAWAS

Twenty-two members were present at a very interesting meeting of the Tuscarawas County Medical Society, March 9, at the Council Chambers in New Philadelphia. The subject was "Rabies", and Dr. H. E. Reed, Dover, was in charge of the program. Participants included Dr. Salt, local veterinarian, and Mr. Jenkins, county dog warden.—D. M. Ceramella, M.D., secretary.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

ATHENS

A good attendance marked a dinner meeting of the Athens County Medical Society, March 9, at the First Presbyterian Church, Nelsonville. The program, arranged through the courtesy of Dr. E. LeFever, Glouster, consisted of a motion picture of a large London Hospital, showing treatment of nervous and mental diseases.—News clipping.

GUERNSEY

At a recent meeting of the Guernsey County Medical Society, the program was presented by two members of the staff of Fletcher General Hospital. Major Rappoport spoke on "Malaria", and Major Benedict discussed "The Treatment of Syphilis". Dr. G. F. Swan recently spoke on "Aphorisms of Surgery", and Dr. Henry L. Wells, gave an address on "Virus Diseases".—M. S. Lawrence, M.D., secretary.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

SCIOTO

The Hemstead Academy of Medicine enjoyed a talk by Dr. J. L. Hutchison, Huntington, W. Va., on "Intervertebral Disc Injuries", at a meeting April 10, at the Portsmouth General Hospital.—T. W. Frame, M.D., secretary.

Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

DELAWARE

Dr. Robert M. Inglis, Columbus, spoke on "Endocrine Disorders", at a meeting of the Delaware County Medical Society, March 21, at Delaware.—F. M. Stratton, M.D., secretary.

FRANKLIN

Dr. Morris Fishbein, Editor of *The Journal of The American Medical Association*, was guest speaker at a meeting of the Columbus Academy of Medicine, April 3, honoring past-presidents and members who have been in practice for 50 years. "American Medicine leads the world to-



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day and will retain that leadership in the post-war world, but that leadership is being threatened by proposed legislation that would set up bureaucratic control of the medical profession", Dr. Fishbein told 300 members of the Academy and their wives. Certificates honoring their 50 years of medical practice were presented to the following physicians: Drs. John A. Bauer, Joseph E. Beery, John Edwin Brown, William H. Cleveland, M. T. Dixon, E. J. Emerick, E. N. Heston, Emma O. Jones, F. F. Lawrence, Lee H. Manns, Joseph A. Murphy, George B. Nessley, James A. Park, Lovett E. Park, H. M. Platter, Oscar C. Ralston, C. C. Ross, Charles J. Shepard, L. M. Sifrit, G. A. Sulzer, Sterling B. Taylor, W. S. Taylor, A. J. Timberman, L. B. Turner, J. H. J. Upham, O. S. Canright, D. W. Collins, Simon B. Winters and G. E. Coburn.

Living past-presidents of the Academy are: Drs. John Edwin Brown, Andrew Timberman, F. F. Lawrence, Chas. J. Shephard, Fred Fletcher, H. M. Platter, J. H. J. Upham, Chas. W. McGavran, E. J. Emerick, I. B. Harris, S. J. Goodman, Joseph Price, James H. Warren, Jonathan Forman, Verne A. Dodd, E. G. Horton, J. Mitchell Dunn, L. N. Jentgen, Wm. B. Morrison, Geo. I. Nelson, Russel G. Means, C. C. Sherburne, H. E. LeFever and George T. Harding.

April 17—"Histamine: Its Use in Clinical Medicine", Dr. Bayard T. Horton, Mayo Clinic, Rochester, Minn.—Bulletin.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

ASHLAND

The Ashland County Medical Society held a joint meeting with the staff of the Ashland Good Samaritan Hospital, March 3, at the Ashland Country Club. Following a brief business meeting, Dr. H. Wayne Smith presented three case reports, namely, "Acute Appendicitis with Retrocecal Abscess and Generalized Peritonitis"; "Perforated Gastric Ulcer"; "Erythromelalgia". Dr. Robert L. Garber, roentgenologist at the Mansfield General Hospital, was a guest.—Reid P. Joyce, M.D., secretary.

LORAIN

Dr. Theron Jackson, Cleveland, spoke on "The Wagner-Murray-Dingell Bill", at a meeting of the Lorain County Medical Society, April 11, at the Lorain Country Club. Wives of members were guests.—L. H. Trufant, M.D., secretary.

WOMAN'S AUXILIARY NEWS

FRANKLIN

J. Herbert Mumma, secretary of the City Board of Health, spoke on "Functions of the Columbus Health Department", at a meeting of the Woman's Auxiliary to the Columbus Academy of Medicine, March 20, at the Columbus Gallery of Fine Arts.

HAMILTON

At a meeting of the Woman's Auxiliary to the Cincinnati Academy of Medicine, March 20, at the Hotel Sinton, Mrs. Dale P. Osborn reported that the school survey on heart disease was nearly finished, and thanked the women who had helped on the project. A letter was read from the Heart Council of Greater Cincinnati thanking the Auxiliary for the assistance of the volunteer workers and inviting two of the members to attend their meetings as associate members of the Council. Mrs. Osborn and Mrs. Warren K. Marvin were appointed as representatives. Mrs. David W. Heusinkveld gave an interesting talk on her activities in promoting the Red Cross Home Nursing Classes.

LUCAS

The Woman's Auxiliary to the Toledo Academy of Medicine has held meetings once a month. The meetings are always luncheons held at the Toledo Woman's Club. There are usually 60 members present. The paid membership is over 200.

The October meeting was a panel discussion on Juvenile Delinquency. The November meeting was on public health problems. During December the women sponsored the Academy Library Drive for new members and assisted in the War Bond Drive with booths in every hospital. The January meeting was a joint meeting with the Academy and was a dinner at The Commodore Perry Hotel with 175 present. Wives of the Acadmey members in service were guests. Dr. Jonathan Forman, editor of *The Ohio State Medical Journal*, was the speaker. The February meeting consisted of informal talks given by members whose husbands are in foreign service; and the March meeting was a talk on the "History of Medical Organization and Its Function", by Dr. John Murphy, Toledo.

MARION

On September 17 the Marion County Auxiliary had a benefit bridge and style show to raise money for furnishing the Doctor's Lounge in the new wing of the Marion County Hospital. This was quite successful. Mrs. Filmore Young, a member of the Auxiliary, asked to furnish the lounge in commemoration of her husband, Dr. F. Young. This was most gratifying, as the Auxiliary was then able to use its funds to buy other much-needed equipment for the hospital.

In February a rummage sale was held. The proceeds were used to buy linens for the new wing of the hospital. Sunday, March 26, the Auxiliary gave a tea for the doctors and their wives of Marion County and surrounding counties. This gave them an opportunity to see the new wing of the hospital before it was opened to the public. The Auxiliary is sponsoring a



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Nurse's Aide class. The class is being taught by Mrs. F. T. Merchant, a member of the Auxiliary.

MAHONING

Members of the Woman's Auxiliary to the Mahoning County Medical Society, whose program this year is dedicated to the development of children in wartime, with emphasis on their needs for health and welfare, heard two interesting talks at their January meeting recently. Mrs. Robert B. Poling, president, presided at the Woman's City Club, and there was a good attendance. Speakers were Dr. Dwight B. Arnold, of the faculty of Youngstown College, who outlined the adjustment work he is doing in the elementary schools, and Judge H. P. Beckenbach, who stressed the need of a child guidance clinic in Youngstown.

RICHLAND

The Richland County Auxiliary added Medical Study to its program this year. Members also worked on the publicity for the recruitment of nurses. Surgical dressings for the Red Cross are made once a week. The Auxiliary has charge of supplies at all O.C.D. casualty stations. The public relations committee contacted the local women's clubs and as a result a number of physicians from the Medical Society addressed the clubs on medical education. War Bonds were sold in all the drives and in the most recent drive, the Auxiliary ranked eighth in the sale of "E" bonds.

ROSS

Ross County Auxiliary met Thursday, March 2, in Chillicothe. Mrs. G. W. Cooper, president, presided at the meeting. The nominating committe was appointed—Mrs. E. Shepard, chairman; Mrs. W. Smith, Mrs. H. Brown, Mrs. R. Counts, and Mrs. R. Lightner. The program consisted of a talk on "Life in the Orient" ,by Mrs. Woodrough, who spent several years teaching in the University of Tokyo.

Fourteen members were present at a meeting of the Auxiliary, April 6. After a short business session, Mr. F. R. Moomaw presented colored movies.

Total hours spent by members of the Auxiliary include: surgical dressings, 400 hours; Red Cross sewing and knitting, 2,500 hours, and sale of bonds and stamps, 75 hours.

SUMMIT

The Woman's Auxiliary to Summit County Medical Society has taken an active interest in all civic affairs, including tuberculosis clinic, hospitals; which consist of surgical dressings, floor duty, and blood bank. The Auxiliary raised money to send two girls through nurse's training.

Meetings are held on the first Tuesday of each month in the Idabelle Firestone Nurses' Home. This is the time and place of the County Medical Society meetings. The Auxiliary serves refreshments to both groups after their respective meetings, and is especially interested in promoting a close social feeling among doctors and wives.

The Mobile Blood Bank from Cleveland spent 72 days in Akron in 1943, collecting 10,134 pints of blood. All volunteer work by graduate nurses was done by the Woman's Auxiliary, 783 hours in all. This year the daily quota has been raised and more hours are needed. This is only one of the projects of the Auxiliary.

At a recent meeting the Woman's Auxiliary joined the doctors in a program at which Dr. R. L. Rutledge, Alliance, Sixth District Councilor of the Ohio State Medical Association, was the guest speaker.

Telling Your Patients Is One of the Best Attacks

"It is essential that every member participate in active opposition to the Wagner Bill now before Congress. In order to defeat this revolutionary and inflationary Act you must act at once. One of the best means of acquainting the public with the seriousness of this situation is to supply the correct information to your own patients." — *The Bulletin of the Cleveland Academy of Medicine.*

Pamphlets which will give a physician information to give to his patients have been published by the Ohio State Medical Association. A supply can be obtained from the Secretary of your County Medical Society or Academy.

Manual on Rescue Techniques

Methods of rescuing persons trapped in buildings demolished by high explosive bombs or in wreckage caused by other types of disasters are described in 'A Technical Manual for the Rescue Service," a 142-page publication just issued by the Rescue Section of the Medical Division of the Office of Civilian Defense. Also the division has just issued a manual entitled "Field Care and Transportation of the Injured", for the training of rescue workers, ambulance drivers and attendants, stretcher bearers, and nonmedical members of mobile medical teams.

Clinic for Women of Low Fertility

As part of its program for planned parenthood, the Cleveland Maternal Health Association has established a special clinic for women of low fertility. The primary aim of this project is to give advice and help to married women desiring families who have not been able to become pregnant. Special studies are being conducted under the direction of the Brush Foundation aiming toward a more certain recognition of the time of ovulation and an understanding of those factors which affect impregnation. The clinical studies of the husband and wife are carried out by the family physician or in regular gynecological clinics of Cleveland hospitals insofar as this is possible.

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WAR NOTES

A native Ohioan, Major General Paul R. Hawley, is top-ranking medical officer in the European Theater of Operations. Recently promoted to his present rank, General Hawley has been in England since September, 1941. He graduated at the University of Cincinnati College of Medicine in 1914, and practiced with his father, the late Dr. W. H. Hawley, at College Corner for a year before beginning his distinguished career as medical officer in the United States Army.

* * *

"I greatly appreciate getting The Journal but I know your circulation department must be going crazy trying to keep up with me", writes Lt. John M. Kidd, Columbus, who recently completed a course at the Mayo Foundation, Rochester, Minn., and now is addressed c/o FPO, San Francisco. Frankly, doctor, it is one heck of a job keeping up with the meanderings of our members in the service, but it hasn't been the source of combat fatigue or war neurosis for any member of our staff—yet. We are thinking of devising some kind of a campaign ribbon for those members who advise us promptly of a change in station—as you did. Members who follow your example save the postal services and our office a lot of trouble, and assure themselves of receiving The Journal regularly.

* * *

Like most members in the service, Capt. Chester R. Lulenski, Cleveland, has retained his sense of humor. He writes from somewhere in England:

"Am receiving your letters and *The Journal* regardless of moving through Africa, Sicily, Italy and now here. The usual thing has happened. We hurry about for a few weeks to wait about for a few months. In this roundabout way to the British Isles I have met several medical officers from Ohio, but in my unit proper there is only Capt. A. B. Chapla, Lorain, who is the executive officer. I would much prefer being in Africa during the winter and here during the summer, but evidently that would un-confuse the enemy too much. As a member of an Airborne Medical Company I have been 'up in the air' many times, but I most like the terra firma—especially that within the confines of Cuyahoga County."

* * *

Lt. Harold C. Klein, Cleveland, now at the AAFFTD, Orangeburg, S. C., says his service record reads like a travel catalogue. He started at Carlisle, Pa., thence to Kearns, Utah; Bainbridge Air Field, Ga.; Newport, Ark.; back to Bainbridge and now in the sunny South Carolina.

* * *

Lt. Col. P. C. Pennington, Findlay, and Major Harry Conn, Toledo, are among a group of Army medical officers placed on Detached Service at the Veterans' Administration Hospital, Hines, Ill., for intensive training as rating specialists in the Adjudication Division.

* * *

Major J. M. Namen, Cleveland, with an Evacuation Hospital, writes that he finds England "very interesting".

* * *

Capt. James M. Foley, Columbus, with a Station Hospital in an island in the Southwest Pacific, writes that his 1944 membership card finally reached him via the Army Medical School, Camp Crowder, Mo., and Camp Stoneman, Calif. He has put the card in "my moldy bill fold with my moldy folding money". Dr. Foley sends greetings to his friends around Columbus and reports an interesting chat with Comdr. Drew L. Davies, another Columbusite.

* * *

Lt. Comdr. W. B. Fessenden, Cincinnati, in on duty at Pass-a-Grille Beach, Fla.

* * *

From Northern Ireland, where he is with a Station Hospital, Lt. Col. H. M. Gunn, Ashland, writes: "We are very well situated and have plenty to do. The weather is on the dripping side but the country very picturesque and the people most friendly. We have a number of Ohio doctors in our unit and we all enjoy seeing our *Journal.*

* * *

Medical officer for a Seabee regiment somewhere out there in the Pacific is the assignment of Lt. Comdr. Robert S. Gillette, Toledo.

* * *

Capt. J. I. Goodman, Cleveland, is on the staff of the Hoff General Hospital, Santa Barbara, Calif.

* * *

Capt. F. Gordon Lawyer, Cambridge, chief of the Section of Dermatology and V. D. officer with a station hospital in England, writes that he has visited some of the dermatological clinics in London. His C. O. is Col. Wilbur Beach, Middle Point. Expressing the hope of most of his colleagues in the service, Dr. Lawyer comments:

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* * *

The Lowry brothers are serving with distinction as chiefs of auxiliary surgical units with the Fifth Army in Italy, according to the Feb. 2 issue of the "Stars and Stripes Weekly", published in North Africa, Commissioned on August 31, 1942, Major Forrest E. Lowry, Urbana, and Major Kenneth F. Lowry, Troy, sailed together for North Africa in November, 1942, and since then have been working together, except for two short intervals, in hospitals and improvised hospital tents. Dr. Kenneth Lowry, in a letter to the State Hdqrs. Office says: "Some of us really have been a bit busy. Indirectly I have learned that you have been putting up a grand fight against the Wagner Bill. Congratulations—please keep it up. We dread thinking that we may have to come back to socialized medicine."

* * *

Major W. R. Hochwalt, Dayton, sends greetings from Australia, where he is chief of the orthopedic section in a General Hospital.

* * *

Capt. F. R. Harrison, East Liverpool, is with the Med. Det., 267th F. A. Bn., Fort Bragg, N. C.

* * *

Lt. H. G. Lehrer, Wadsworth, recently left the School of Aviation Medicine, Pensacola, Fla., for fleet duty.

* * *

Capt. John S. Meyers, Versailles, is now stationed at Presidio of Monterey, Calif., and is assigned as surgeon of Hdqrs. Co., III Corps. He was recently promoted to his present rank.

* * *

Chief of surgery with the 111th Evacuation Hosp., Camp Swift, Texas, Lt. Col. George L. King, Jr., Alliance, has been on active duty since July, 1941. He spent two years as chief of EENT, General Dispensary, Pentagon, Washington, D.C., and is happy to be attached to a more active unit.

* * *

H. Worley Kendell, Surgeon (R) USPHS, Dayton, is medical director of the Chicago Intensive Treatment Center, a project of the Chicago Health Department in cooperation with the United States Public Health Service. He is one of the authors of a preliminary report on the organization, objectives, activities and accomplishments of the center, in "The Intensive Treatment of Gonorrhea and Syphilis", which was published in the No. 27, 1943. issue of *The J.A.M.A.* Dr. Robert M. Craig, Ass't Surgeon (R) USPHS, Dayton, is also on duty at the center.

* * *

"Extremely interesting and absorbing" is the comment of Capt. N. G. Amato, Cincinnati, on his duties as flight surgeon with the Army Air Forces Ferrying Command at Nashville, Tenn. He reports that the medical officers there were fortunate to be able to attend an excellent course of 10 sessions in surgery at Vanderbilt University School of Medicine, Nashville.

* * *

Lt. Comdr. O. J. Fronek, Cleveland, is a flight surgeon attached to the NOATC at Jacksonville, Fla. He has been on duty there since October, 1942, and hopes to go to sea soon as a senior medical officer on a small aircraft carrier. He reports that Lt. Comdr. R. G. Witwer, Cleveland Heights, is also a flight surgeon, at the USNAS, New Orleans.

* * *

The Army venereal disease rate reached a record low of 27 cases per 1,000 men during 1943, according to preliminary figures. Comparative figures were: 38 per 1,000 men in 1942; 40.5 in 1941 and 42.5 in 1940. In the Civil War the rate reached 214 per 1,000, in the Spanish-American War, 133; while in World War I the rate went to 107 in 1918.

* * *

Hearty congratulations to Dr. Wm. A. Neill, Toledo, who was recently promoted to the rank of Captain in the U.S.N.R. He is with a Navy Air Corps Group at San Diego. (For civilian readers: The rank of Captain in the Navy is comparable to that of Colonel in the Army.)

* * *

Witnessing one of the worst aircraft accidents in the history of American aviation when three Mitchell B-25's were completely demolished and 19 men killed, hasn't dampened the enthusiasm for flying of Capt. Luther W. High, Millersburg, on duty with the 473rd Bomb. Sqdn., at the AAB, Greenville, South Carolina. The accident occurred while 24 of the Mitchells were flying formation during a review of ground troops.

* * *

Major Robert C. Kirk, Columbus, now at the Cantonment Hosp., Ft. Sill, Okla., liked "the wording and expressions" of the Executive Secretary's letter accompanying his 1944 membership card. Writes Dr. Kirk: "One of the great medical problems of this army is keeping men in good health and good spirits with letter after letter from home concentrating on the trials and tribulations of the writer. A man can't perform to his utmost if he is worrying about the high cost of living and the transient, real or imagined

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pains, of the folks back home." (Good thought there for folks who are writing to men in the service.) Dr. Kirk continues: "I am pleased and proud to belong to an organization which has been so unstinting in its effort to keep its military members informed 'as usual'. I certainly appreciate the privilege of membership, and receiving *The Journal* without obligation."

* * *

From far off China, where he is with a portable surgical hospital unit, writes Capt. A. W. McConkey, Canton: "I have traveled 19,000 miles by rail, ship and air and then by jeep over ox-cart trails to locate a Chinese Temple about 350 years old. Life here is neither dull nor tedious. The weather is perfect, permitting sun baths nearly every day. I find the altitude is a little difficult to get used to.

"The Chinese Army and civilians seem very grateful for our coming here and entertain us in their own royal way. The feasts are lavish as to food and compliments. My unit is well situated. Our commanding officer has covered himself with glory and Chinese decorations already by saving the life of a Chinese general with an appendectomy. We are all in the best of health and morale is high. We'll do our best to hurry this thing through."

* * *

Many newly commissioned medical corps officers who have recently completed a nine months' internship and the basic course for medical department officers are being attached to named general hospitals for the completion of their professional training, according to Army Service Forces Circular No. 47, dated Feb. 12, 1944. The commanding officer of each general hospital will designate a training officer who will be responsible for this training, which is to include ward rounds and clinics. Duty assignment on surgical and medical services will be rotated at least once every three weeks. It is contemplated that immediately following this training in a named general hospital these officers will be assigned as medical and surgical ward officers, as laboratory officers and as medical officers with tactical units.

* * *

One hundred Navy nurses, the first to set foot on European soil since the beginning of the war, have arrived in England for assignment to duty in a British hospital which is being taken over by the Navy.

* * *

Lt. Col. J. J. Brumbaugh, Canton, who is starting his fourth year of foreign duty in two theaters of war, as executive officer of a station hospital, writes: "I am sure you are doing all that is possible to maintain medical practice procedure in view of the postwar period. Over here, we do not have the opportunity to follow medically the home front as close as we would like to and consequently depend upon your judgment and decisions. You seem so far away and even to the point of obscurity due to distance and time."

* * *

Capt. B. Widzer, Cleveland, is war officer for the AAFTAC, Orlando, Fla.

* * *

Lt. Col. F. M. Wadsworth, Mansfield, who has just completed his third year of active duty, reports having seen a number of Toledo, Cincinnati, Cleveland, Dayton and Columbus physicians in England.

* * *

Also from England, Major Walter J. Tims, Youngstown, writes that he recently visited a General Hospital unit which is composed largely of Cincinnati physicians. Dr. Tims has been in the European Theater of Operations for 19 months.

* * *

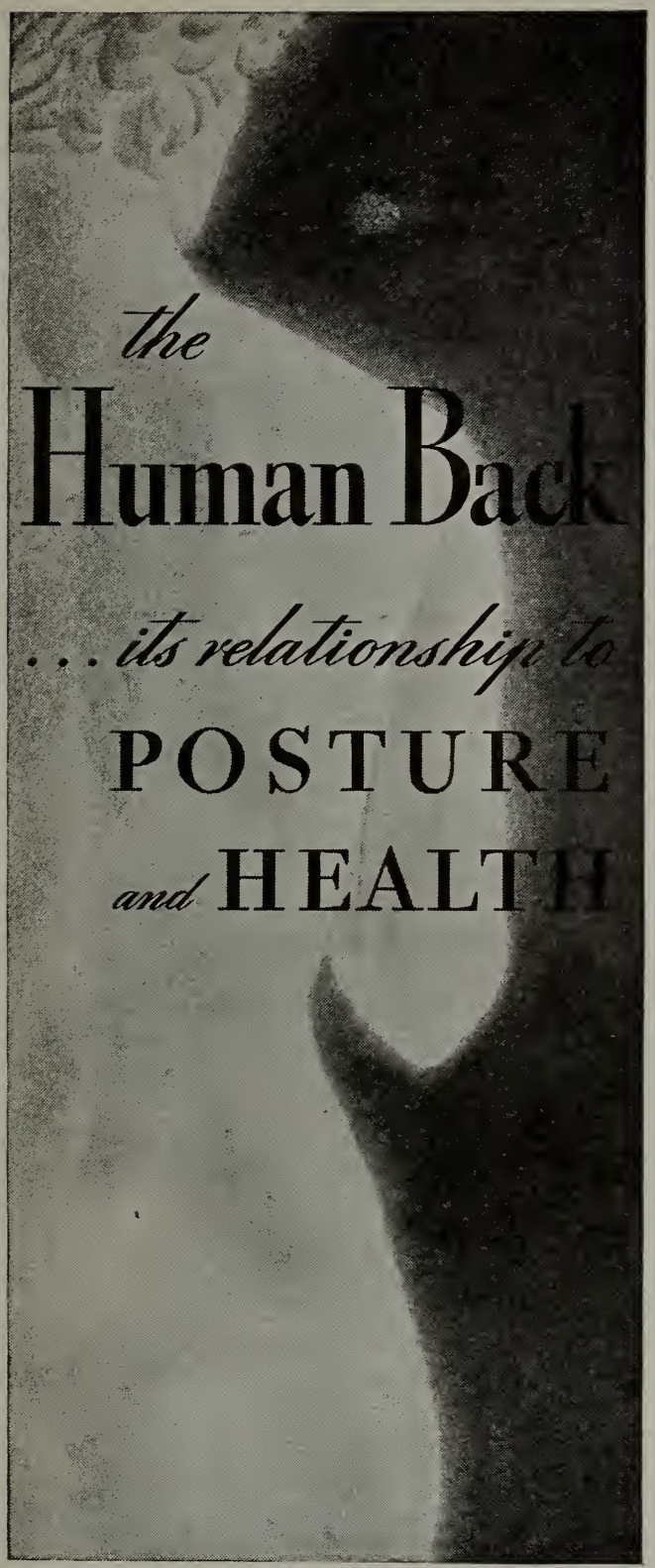
Capt. Nathan R. Abrams recently visited his home in Cincinnati after two trips overseas as medical officer on troopships. He has been in Africa, Sicily and England.

* * *

From India, where he is attached to an air depot, Capt. Emery J. Brown, Akron, writes that he enjoys reading *The Ohio State Medical Journal.*

* * *

While President of the Columbus Academy of Medicine last year, Dr. George T. Harding sent several news-packed letters to Columbus physicians in the service with news and comments from their colleagues in the service. Following are some excerpts from Dr. Harding's letter of Feb. 15. . . . Capt. N. O. Rothermich, with a station hospital in New Guinea, Lt. Col. John H. Marshall, Findlay, his CO. . . . Capt. Tom Rardin, training officer at the AAF Med. Serv. Tng. Schools, Robins Field, Warner Robins, Ga. . . . Lt. C. C. Landen, in the India-China theater of operations, getting plenty of experience in the treatment of tropical diseases, sees Lt. Col. Hardy Kemp occasionally. . . . Capt. Charles W. McGavran, II, at the station hospital, Long Beach, Cal. . . . Major John J. Gallen, with Ohio's own—the 37th Div., has tangled with the Nips plenty. Fiji Islands, Guadalcanal, New Hebrides, Munda, New Georgia . . . mentions names familiar to many. . . . Lt. Col. John Blinn, New Philadelphia, named to command the medical battalion after Lt. Col. Hobart Mikesell, West Liberty, returned to the States. . . . Major Vic Kolb, South Charleston, executive officer (now at Percy Jones Gen. Hosp., Battle Creek, for treatment). . . . Major Don Forward, Ashtabula, division medical



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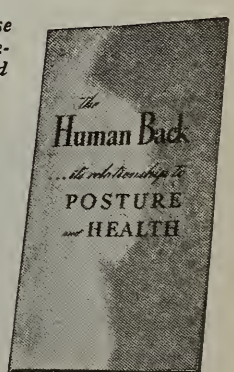
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inspector. . . . Capt. Ed. Klopfer, with the clearing company, and the most recent arrival—Lt. Ralph Phillips, who was swamped with all kinds of questions about Broad and High. . . . Capt. Bob Myers, anesthetist with an auxiliary surgical group in England. . . . Capt. Bill Andrus, chief of medicine with a station hospital, hoping to go overseas soon. . . . Capt. Albert V. Black, acting chief of the medical service with a station hospital organized in Dayton, now in England, recently saw Major Frank E. Hamilton. . . . Capt. John Quincy Brown, with a station hospital in New Guinea. . . . Lt. Robert G. Smith, USNR, on a battleship (censorship does not permit naming it). . . . Capt. Bill Harris (son of "I.B.") in New York taking a special course in "Traumatic Surgery of the Extremities" at Columbia, preparatory to returning to the surgical service in a hospital at Charleston, S.C. . . . Major James R. Reeves, division medical inspector, "somewhere in the Pacific". . . . Major Richard C. Carlisle, at the Toxicological Research Lab., Edgewater Arsenal, Md. . . . Capt. Oscar Coddington attended the medical officers' course at the Chemical Warfare School there. . . . Capt. Ervin B. Wallace, with a station hospital, "in the beautiful rolling country of southern England, well and full of pep".

* * *

Lt. Comdr. C. B. Elliott, Painesville, with a Seabee unit in the South Pacific, has been slightly wounded, according to information received by his wife.

* * *

Lt. J. H. Bolotin, Warren, is on duty at a prisoner-of-war camp at Ruston, La.

* * *

Among the many Ohio medical officers "somewhere in England" is Major Von B. Barnhiser, Camden.

* * *

Lt. William S. Banfield, Irondale, is with a Seabee outfit in the South Pacific.

* * *

Major D. R. Brumley, Tiffin, is chief of EENT of the new Crile General Hospital, Cleveland.

* * *

Capt. Walter J. Brown, Conneaut, has been transferred back to the states from Alaska. At present home on a 30-day leave, he expects to be reassigned to active duty soon.

Capt. Carl R. Damron, Mansfield, is with the 105th Evacuation Hosp., Ft. Jackson, S. C.

* * *

Lt. Col. Wallace S. Duncan, Cleveland, was recently transferred to the Station Hosp., Buckley Field, Denver, Col.

Capt. Homer J. Daus, Cleveland, assistant battalion surgeon in North Africa, Sicily and Italy, writes that malaria, jaundice and venereal diseases constitute most of the medicine he has seen in nine months' overseas.

* * *

History is repeating itself in the case of Major John T. Gibbons, Celina. During World War I he saw service as a medical officer in England, France and Belgium. Now he is back in England with an evacuation hospital unit.

* * *

Lt. Comdr. David R. Talbot, Mansfield, has been transferred to duty at the U.S. Naval Hospital, Philadelphia.

* * *

Many Ohio lads have passed through the portals of a medical field service school in which he is teaching in England, writes Major Kenneth M. Smith, Columbus. He has been there for 16 months, but "would gladly transfer for one square foot of the States any day now".

* * *

Capt. L. S. Shensa, Youngstown, is in charge of fever therapy at the Lawson General Hosp., Atlanta.

* * *

Chief of surgery at the Naval Base, Port Hueneme, Calif., is the assignment of Comdr. William J. Sheehan, Cleveland.

* * *

Back home after 14 months with the Navy in the Aleutians, Lt. J. M. Sharp, Cincinnati, is now medical officer with the V-12 Unit, Case School of Applied Science, Cleveland.

* * *

From a desert post in Persia, where he has been post surgeon since the Spring of 1943, writes Capt. N. E. Williard, Tiffin, that he receives *The Journal* every month, though it is usually three months late. Dr. Williard says he seems to be the only Ohio medic in his immediate vicinity, although he did see Dr. B. E. Pet-

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coff, Toledo, while on a trip last summer. Following are some excerpts from his letter—one of the most interesting received at the State Hdqrs. Office:

"We are located in one of the hottest inhabited spots in the world. For months last Summer the daily temperatures were 125 to 160 degrees with very little cool off at night. Already this Spring we have had temperatures of 112, and that is just a suggestion of hotter days to come. When we first arrived here very little of the construction work was completed, so of course we lived in tents for weeks. All our buildings are of the adobe or mud type and have walls two to three feet thick with mud roofs which will help to keep out some of the heat.

"Last summer the natives told us 'July the month all the flies die, August the month Johnnie die'—meaning that it would get so hot in July that all the flies and insects would die and during August it would be even hotter and then we would die. But we fooled them, and although we did have a number of cases of heat stroke and prostration we did not have one death. Of that record I am quite proud, and I feel that I am almost an authority on the treatment of heat stroke. Since we employ hundreds of the natives we have to give them medical attention and I have learned to diagnose and treat the Asiatic and Tropical diseases that are common to this part of the world.

"We all thought that white men could not spend two Summers here on this desert, but it does look as though we will be right here again when 'the heat is turned on'. At least this year we will not have to begin with practically the bare desert and build the post, so that should be in our favor. In another six weeks the men will only be able to work from six in the morning until noon—then everyone takes a 'siesta' period for the rest of the day. Really such temperatures are beyond description. Had anyone ever told me it could get so hot and stay that way for weeks I would just never have been able to comprehend such heat."

* * *

Capt. H. O. Crosby, Findlay, with a field artillery battalion on the Anzio beachhead, writes that he continues to receive The Journal regularly and enjoys every page of it. Says he: "There is not much to tell you at present, except that Rome isn't too far away."

* * *

Capt. Wm. Shannon, Cincinnati, is at the Station Hosp., MacDill Field, Tampa, Fla. He was previously on duty in the Caribbean Area.

* * *

Commanding officer of the Clearing Company of the 32nd Inf., during the Buna campaign, Capt. R. P. Scott, Norwalk, is at the Hoff General Hosp., Santa Barbara, Calif., waiting reassignment. He had been in the South Pacific for nearly two years.

* * *

Capt. O. F. Rosenow, Columbus, has been transferred to the AAF Station Hosp., Port of Newark, Newark, N.J.

The new address of Capt. H. J. Riemer is the Station Hosp., Camp Haan, Calif.

* * *

Major W. C. Robart is with the Veteran's Administration at Wood Wis.

* * *

Capt. Isador Miller, Urbana, V-mails that he has been in North Africa for 11 months, most of the time on detached service in a small hospital close to an air base. He reports having met the following Ohio doctors: Nathan Aronoff, Leipsic; Kenneth Lowry, Troy; Dave Frankel, Cincinnati; and Ben Wiltberger, Columbus. He corresponds regularly with Irving Albert, Cincinnati, in Australia; and Carl Kumpe, Hillsboro, and Fred Somma, Dayton, both in England.

* * *

Another interesting V-mail letter comes from Capt. J. W. Pastor, Cleveland, who is now with a field hospital in China, after having been in India for some time. Other Ohioans in the outfit are Capt. Lewis Inskeep, Urbana, and Capt. William Catalona, Cleveland. Dr. Pastor says the people of China are much more interesting than in India and living conditions are much better. In another theater of war he met Major J. Ockington, Lakewood, and Lt. Chester Nuckols, Cleveland, medical officer on a naval ship. The three physicians had trained together at St. Alexis Hospital, Cleveland.

* * *

Major Robert J. Tapke, with a Station Hospital in India, writes that he has plenty of surgery to do and is enjoying his work. He has also done some surgery in a local American Baptist Mission Hosp., which he compliments very highly for its marvelous work over there.

* * *

Major W. L. Faul, Georgetown, and Capt. Robert C. Markey, Dayton, are with an evacuation hospital in the Southwest Pacific.

* * *

Major Robin C. Obetz, Columbus, is chief of medical, X-ray and laboratory services at the station hospital, Walterboro Army Air Field, South Carolina.

* * *

Capt. G. G. Picard, is another one of the rapidly-growing Cleveland contingent in England. He is with an engineering combat bn.

* * *

With a Seabee contingent somewhere out there in the Pacific is Lt. Comdr. E. W. Peters, Cleveland.

* * *

An AP story from Sardinia describing a Marauder squadron celebration after a successful mission over Italy, mentions Capt. George A.

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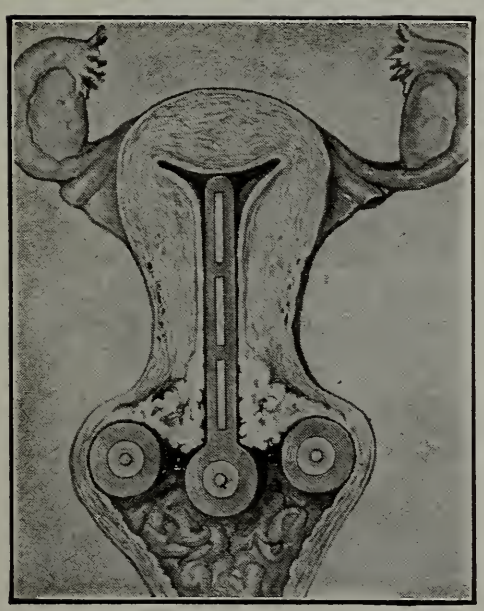
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Peabody, Cleveland Heights, a member of the class of 1940 at Western Reserve. It says: "The 29-year-old squadron doctor jackknives his long angular frame up on the table and starts a song. The chorus shakes the roof."

* * *

From a field hospital in the jungles of that hot spot, Burma, Capt. L. J. Lester, Cleveland, writes that he has been receiving his Journal regularly. He says: "Living is rough, with plenty of mud, leeches and insects. But we still manage to carry on all the essential functions of a hospital. I'm on the surgical service and have done all sorts of surgery from opening a boil to splenectomies and intestinal resections. We are working with Chinese troops and they have a fine sense of humor and make good patients. There are two other Ohioans in our outfit—Major W. B. Merrill, Columbus, and Capt. A. A. Mancin, Cleveland, (dentist)."

* * *

Capt. Clarence T. Risley, Conneaut, was recently transferred to the AAF Station Hospital, Municipal Airport, Memphis, Tenn.

* * *

A home-state assignment is that of Capt. L. H. Skimming, Middletown, now at the Crile General Hospital, Cleveland.

* * *

Capt. Nathan Silver, Cincinnati, with an evacuation hospital in England, is doing internal medicine, besides teaching nurses and enlisted men. He recently met a classmate, Capt. Fred Somma, Dayton, University of Cincinnati, Class of '38.

* * *

Capt. William T. Sharp, Chillicothe, is base surgeon at the AAB, Lawson Field, Ft. Benning, Ga.

* * *

From Brazil comes an appreciative acknowledgment of his 1944 membership card by Capt. Trent E. Smith, Cincinnati, a base flight surgeon with the AAF, and now in his 14th month of foreign service. Several months ago, Major Philip Knies, Columbus, came through the base on an inspection trip.

* * *

Capt. Bert A. Treister, Cleveland, is chief of psysiotherapy at the Station Hospital, Fort Knox, Ky.

* * *

Now on dispensary duty at the Armored Replacement Training Center, Capt. Nathan R. Abrams previously was at the New York Port of Embarkation. He made several trips to the Mediterranean area and the British Isles as a transport surgeon.

Lt. R. N. Whitehead, Bowling Green, has been at sea in the Pacific theater for more than a year as a junior medical officer. He reports "active and interesting duty, with excellent equipment and facilities", and also a "splendid S.M.O.".

* * *

With a fighter squadron in New Guinea is Capt. R. G. Smith, Painesville.

* * *

English physicians feel about like their American colleagues regarding state medicine, according to this clipping from the *London Daily Express*, March 27 issue, received from Lt. Col. Claude S. Perry, Columbus:

100 Doctors Say 'No' To State Control

About 100 doctors from London, Surrey, Kent, and Berkshire, unanimously decided yesterday to oppose any State medical service and any further encroachment upon the freedom of doctors.

"We will not stand for regimentation and will not have central control impossed on us", said one doctor.

They met at Guildford and were told by Sir Ernest Graham-Little, M.P. for London University, that 90 per cent of doctors were opposed to the Government scheme.

* * *

Capt. Laurence O. Fasoldt, Glendale, is in New Guinea with the Troop Carrier Service.

* * *

Lt. William H. Gitman has been enjoying a 30-day sick leave at his home in Dayton, after nine months in the South Pacific combat zone. Dr. Gitman was disabled in the fierce fighting of the Munda campaign on New Georgia island and has been hospitalized at McClosky General Hospital, Temple, Tex.

* * *

Major John R. Alley, Greenville, is at the AAF Regional Station Hosp., Pyote, Texas.

* * *

Major Howard D. Fabing, Cincinnati psychiatrist, is doing a superb job of teaching a course on psychoneurosis in a military-medical school in England, according to one of his recent students, Capt. Basil D. Anagnost, Toledo.

* * *

Major S. H. Eisenberg, Akron, and Capt. George Gressle, Newark, are with an air depot group now attached to the Ninth Air Force in England.

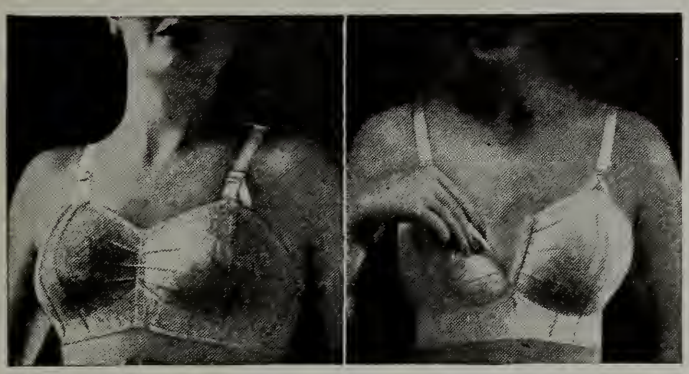
* * *

Major William E. Elliott, Alliance, is asst. chief of the surgical service and chief of general surgery, with the 141st General Hospital group, at Kennedy General Hospital, Memphis, Tenn.

* * *

Capt. Jos. Gross, Cleveland, with a service group in England, writes that "in a world dealing with latrines, mess sanitation and sewage disposal, a medical magazine is something to restore one's sanity". Dr. Gross was in England

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for two months before he met up with his younger brother, Dr. Alex Gross, also of Cleveland.

* * *

Lt. Col. Russell J. Caton, Bucyrus, V-mails from the Hdqrs. of a Service Command in the Pacific: "I will soon complete two years in this theater. As island surgeon at this base, I have been instrumental in the organization of the ---------- Army Medical Society. We have bi-weekly meetings and often have an atttendance of 300. Some of our essayists are men outstanding in the field of medicine. Hope to hold a meeting in Tokyo some day." The sooner you can arrange that meeting, doctor, the happier we'll all be.

* * *

Capt. H. H. Gibson, Akron, is with a Station Hospital in Naples, Italy.

* * *

At sea on a ship, c/o FPO, New York, is Lt. Geo. E. Gardner, Lancaster.

* * *

Capt. Ronald M. Harner, Canton, writes that the *O.S.M.J.* is part of the medical library of his station hospital in Italy.

* * *

Capt. William Hepp, Norwood, with a field artillery battalion in England, would like to see some of his colleagues from around Cincinnati. We could give you a couple of clues, doctor, but censorship regulations forbid.

* * *

Lt. Comdr. L. B. Hurliss, Dayton, finds his work very interesting as ward medical officer of the U.S. Naval Hospital, Santa Margarita Ranch, Oceanside, Calif. Lt. Comdr. Clair B. King, Canton, is at the same location.

* * *

Comdr. Harry R. Huston, one of the Dayton specialist group called into service by the Navy in January, 1942, has been awarded a naval citation "for meritorious performance of duty while serving at the first advanced Naval Base hospital to be established in the South Pacific area during the period from April 12, 1942, to Nov. 27, 1943". He is now on duty at the Great Lakes Naval Training Station, Great Lakes, Ill.

* * *

Capt. Herman A. Kling, Youngstown, back in "the good old U.S.A.", though a patient at Billings General Hospital, Indianapolis, says he is "being salvaged for continued army service".

* * *

His post as surgeon for the Prisoner of War camp at Camp Campbell, Ky., "is extremely interesting and furnishes a world of clinical experience", writes Major Harry G. Brown, Cincinnati.

Lt. J. P. Hochwalt, Lebanon, in the South Pacific area, has missed the last several issues of *The Journal*. We hope this one gets through, doctor.

* * *

Comdr. Marion W. Coleman, Dayton, is now at the U.S. Naval Hospital, Oakland, Calif.

* * *

Capt. Frank S. Downey, Sidney, is with an Evacuation Hospital in England.

* * *

Lt. Comdr. W. B. Faircloth, Zanesville, is senior medical officer aboard a ship, c/o FPO, San Francisco.

* * *

Capt. Stanley E. Turel, Cleveland, with a station hospital in Australia, has been "down under" for over two years.

* * *

Capt. Gerald Vorhies, Scio, reports from England that he has not received his *Journal* for several months, "due to moving a lot frequently". And he continues (much to the delight of the staff): "I have missed it more than I thought I would".

* * *

Capt. L. D. Bonar, Mansfield, Army flight surgeon in England, "Has been on a few missions over enemy territory, but has not, as yet, encountered the enemy".

* * *

Another Ohio flight surgeon, Capt. Alex Pollack, Columbus, is stationed in New Guinea.

* * *

Major N. A. Martin, Gallipolis, recently returned from strenuous service in the South Pacific, has been assigned to the staff of the Hass General Hospital, Santa Barbara, Calif.

* * *

Lt. Robert Srigley, Columbus, has been transferred from the Lawson General Hospital, Atlanta, Ga., to take a four months' course in neuro-surgery. He is to spend one month at the University of Pennsylvania, and then three months in a general hospital.

* * *

Lt. Robert G. Smith, Columbus, back home on leave for the first time after 14 months aboard one of the big battle-wagons in the Pacific, was a welcome visitor at the State Headquarters Office recently. Dr. Smith has been in plenty of action, including Tarawa and Kwagalein.

* * *

With the activation of a 2,000 bed general hospital at Camp Atterbury, Ind., there are now eight Army general hospitals in the Fifth Service Command, comprising Ohio, Indiana, West Virginia and Kentucky. Others are: Billings, Fort Benjamin Harrison, Indiana; Crile, Parma



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* * *

Lt. Col. F. C. Potter, Akron, stationed at Fort Benjamin Harrison, Indiana, has been elected to honorary membership in the Indianapolis Medical Society. Only 10 persons have achieved this distinction in the Society's history.

* * *

Approximately 173,000 wounded and sick patients of United States and allied forces were evacuated by American military aircraft throughout the world in 1943, with only 11 deaths in flight, Maj. Gen. David N. W. Grant, the air surgeon announced recently.

* * *

Squadron surgeon with a combat mapping squadron, including some flying as a flight surgeon, is the assignment enjoyed by Capt. John J. Clark, Mansfield, somewhere west of San Francisco. Expressing his appreciation of The Journal, Dr. Clark says: "We brethren on the fringes fear forgetting our medical knowledge and falling behind with respect to new medical advances more than the accepted inconveniences and crises of military life."

* * *

Recently promoted, Major Allan A. Cole, Logan, is at the Station Hospital, Robbins Field, near Macon, Ga.

* * *

Chief of the urological section of the station at the Sioux Falls, So. Dak., Army Air Field, is the assignment of Major James K. Nealon, Newark.

* * *

Major C. W. Berry, Wapakoneta, has been on duty with the AAF in India for over a year. His family recently received a number of souvenirs obtained while he was on a two weeks' leave in Tibet.

* * *

Lt. Col. Hobart L. Mikesell, West Liberty, who recently returned from the South Pacific where he was commanding officer of the 112th Medical Bn., 37th Division, has been assigned to the Mayo Foundation, Rochester, Minn., for a three months' course in surgery.

* * *

Capt. Milton Axthelm, Caledonia (Marion County), also is with an evacuation hospital unit in England, following a postgraduate course in surgery at the University of London.

* * *

Maj. Gen. Harry L. Gilchrist, M.C., U.S.A., ret., who was commanding officer of the Lakeside Hospital Unit when it reached England in May, 1917, died in Washington, D.C., December 26. He was 73 years old.

News Notes

Ashtabula—A report on the progress made by medical science in lowering the loss of life of the wounded in World War II as compared with those in World War I was made by Dr. C. C. Crosby, Ashtabula County Health commissioner, at a meeting of the Business and Professional Women's Club.

Bellefontaine—Dr. L. E. Traul will head the newly combined Logan-Shelby County health district.

Castalia—Dr. and Mrs. Smith Gorsuch recently observed their golden wedding anniversary.

Cincinnati—Dr. L. Howard Schriver, President-Elect of the Ohio State Medical Association, spoke in opposition to the Wagner-Murray-Dingell Bill at a recent meeting of the League of Women Voters.

Cleveland—Socialized medicine as proposed by the Wagner-Murray-Dingell bill is a distinct threat to American initiative and private enterprise, Dr. F. Lamber McGannon, Lakewood, told members of the Brooklyn Kiwanis Club.

Columbus—Dr. Jonathan Forman spoke on "The Relation of Soil to Human Nutrition", at a meeting of the Cleveland Dietetic Association.

Crestline—Dr. Carl A. Marquart has been reelected president of the board of directors of the Crestline Emergency Hospital.

Dayton—"Caudal Anesthesia" was the subject discussed by Dr. J. H. Prince at a meeting of the Montgomery County Obstetrical Society.

Findlay—Dr. C. S. Mundy, Toledo, reviewed the Wagner Bill and its implications at a meeting of the Rotary Club.

Mansfield—Dr. Charles R. Keller spoke on "Socialized Medicine" at a meeting of the Optimist Club.

Marysville—Union County commissioners, township trustees, and representatives of the Medical Society are working on the possibility of a county hospital as a postwar project.

Mt. Vernon—Dr. Stephen A. Douglass, Paterson, N. J., for several years superintendent of the Ohio State Tuberculosis Sanatorium, has been reelected president of the New Jersey State Tuberculosis Society.

New Philadelphia—Dr. John Srail, superintendent of the Tuscarawas County Tuberculosis Hospital for 18 months has resigned to become clinician for the Washington State Tuberculosis Association. Dr. Srail was head of the Clark County Tuberculosis Hospital at Springfield for a number of years.

Oak Hill—Dr. Brinton J. Allison has been reappointed health commissioner of Jackson County.

Shelby—Dr. B. H. Moffatt has been elected chief of staff of Memorial Hospital, succeeding the late Dr. H. H. Metcalfe.

Toledo—New staff officers of Toledo Hospital are: Dr. Lewis F. Smead, chief; Dr. John L. Stifel, vice-chief and Dr. Glenn H. Reams, secretary-treasurer.

Troy—The effect of the present war on the practice of medicine was discussed by Dr. George E. McCullough at a meeting of the Rotary Club.

Upper Sandusky—Dr. Jonathan Forman, Columbus, spoke on the Wagner Bill at a joint meeting of the Wyandot County Medical Society, Rotary Club and Chamber of Commerce.

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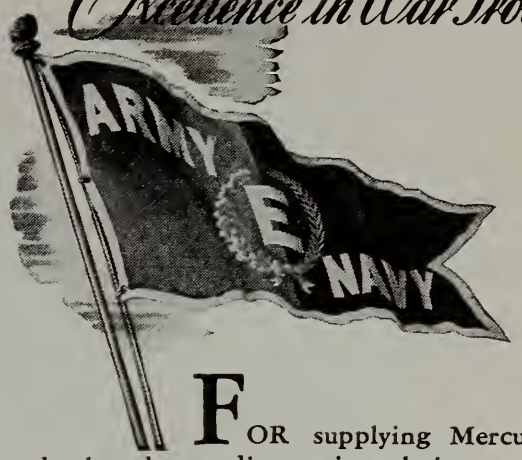
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A total of 328,121 injury and occupational disease claims were filed with the State Industrial Commission last year, an increase of 9,973 over 1942.

* * *

Dr. William T. Corlett, professor emeritus of dermatology, Western Reserve University School of Medicine, Cleveland, was 90 years old on April 15.

* * *

Dr. James A. Doull, professor of hygiene and public health, Western Reserve University, was re-elected president of the Cleveland Child Health Association. He is now in London on a special mission for the United Nations Relief and Rehabilitation Administration.

* * *

The W. K. Kellogg Foundation recently gave Ohio State University $4,000 for the creation of a loan and scholarship fund for students in the Department of Occupational Therapy. The dedepartment has been approved by the Council on Medical Education and Hospitals of the American Medical Association.

* * *

Henry J. Robison, chief of the Division of Social Administration, State Department of Public Welfare, has been reappointed by Governor Bricker as a member of the Ohio Commission for the Blind, for a term ending July 7, 1948.

* * *

New officers of the Ohio Hospital Association are: Lee S. Lanpher, Lutheran Hospital, Cleveland, president; Van C. Adams, Jewish Hospital, Cincinnati, president-elect; Georgia Gillis, Memorial Hospital, Fremont, first vice-president; Sister Francis Marie, Good Samaritan Hospital, Dayton, second vice-president; Msgr. M. F. Griffin, Cleveland, treasurer.

* * *

Dr. Clyde L. Cummer, Cleveland, spoke on "Contact Dermatitis", at a recent meeting of the Columbia Medical Society, Columbia, S.C.

* * *

In recognition of outstanding services to the order, the Elks Lodges of Ohio honored Dr. Edward J. McCormick, Toledo, Past Grand Exalted Ruler, by naming all classes of candidates initiated through the state during March in his honor.

* * *

J. Louis Neff, Long Island, N. Y., who has been executive secretary of the Nassau County Medical Society since 1923, has been appointed executive director of the American Society for the Control of Cancer.

In a recent address in Sheffield, England, Herbert Morrison, Home Security Minister, said that 50,324 British civilians had been killed by bombs and 163,075 had been injured, since the start of World War II.

* * *

The Columbus Academy of Medicine has purchased a number of view boxes which are being put to good use by local roentgenologists in presenting selected films of interesting and unusual conditions, and being on hand to explain them, prior to the Academy meetings.

* * *

Dr. W. H. Bunn, Youngstown, has been elected a director of the American Heart Association.

* * *

Accidents killed 94,500 persons in the United States during 1943, and injured 9,700,000, according to an announcement by the National Safety Council.

* * *

The Annual Spring Clinic Meeting of the Cleveland Dental Society will be held at Hotel Carter, Cleveland, May 8, 9 and 10.

* * *

At the recent annual meeting of the Cleveland Medical Library Association a portrait of Dr. Geo. Edw. Follansbee, a past president and distinguished member, was accepted for the library by the retiring president, Dr. Frank Gibson. It was painted by David Cleland. Dr. Follansbee is chairman of the Judicial Council of the American Medical Association and a former president of the Ohio State Medical Association.

* * *

The treatment by the Japanese of the 3,900 internees, about 80 per cent of whom were Americans, in a concentration camp in Manila, was characterized chiefly by indifference, with close confinement and the lack of adequate food, medical and drug supplies a constantly increasing menace, Dr. Frank E. Whitacre, Sylvania, repatriated on Gripsholm, reported in the March 4 issue of *The Journal of the American Medical Association.*

* * *

Ohio's old age pension rolls dropped over 8,000 during 1943, numbering 130,323 at the end of 1943 as compared with 138,402 at the close of 1942. During the first 11 months of 1943, only 11,897 applicants asked for assistance, with 8,761 of these meeting the eligibility requirements and being granted aid. In 1942, the Division of Aid to the Aged received 16,773 applications while in 1941 the number of applicants amounted to 25,325. The average monthly award for 1943 was $27.45. Average age of the pensioners is around 74 years.

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Introduction To Foods and Nutrition, by H. C. Sherman and C. S. Lanford, ($2.00. *The MacMillan Co., New York City)* goes at once to the crux of the new foods for the nutrition and nutrition for the food cause. As could be depended upon, its authors have done a splendid job. Just a suggestion to physicians: Unless your wife or daughter is nutrition-trained, this is the book to give them the background that a physician's family is supposed to have these days.

Internal Medicine In General Practice, by Robert Pratt McCombs, M.D., ($7.00. *W. B. Saunders Co., Philadelphia, Pa.)* is a concise volume which grew out of the peacetime experiences as instructor in the Statewide Postgraduate Course in Internal Medicine given under the direction of the Tennessee State Medical Association. It therefore contains just the points upon which most of us need refreshment. Good book to have with you for spare time reading.

The Compleat Pediatrician, by W. C. Davison, M.D., ($3.75. *Duke University Press, Durham, N.C.)* summarizes under alphabetical letter 13,-054 pediatric articles. We should all take hold of this fact that "Of the 329 diseases to which children are heir, only 100 are important, i e., 63 which are responsible for 21 per cent of the pediatric deaths and respond to adequate therapy; and 37 which cause 56 per cent of the deaths in children and which can and should be prevented." The book is full of wisdom made readily accessible.

Understand Your Ulcer, by Burrill B. Crohn, M.D., ($2.50. *Sheridan House, New York City)* has been written by this outstanding authority for your patient. It attempts to explain to him the most recent developments in our understanding of the disease. If you read, you acquire many facts heretofore not known by you.

The Manual of the Diseases of the Eye, by Charles H. May, M.D., and Charles A. Perera, M.D., ($4.00. New 18th Edition. *William Wood Co., Baltimore Md.*) still retains its well-deserved popularity. There have been three reprints since the appearance of the preceding edition in 1941. This allows careful revision and rewriting, especially of the chapter on Diseases of the Lacrimal Apparatus and the chapter on Errors of Refraction. This volume still remains the best text for students and others not specialists in the field.

1943 Yearbook of Industrial and Orthopedic Surgery, edited by Charles F. Painter, M.D. ($3.00, *Yearbook Publishers, Inc., Chicago, Ill.)* is colored pretty largely by things military. War casualties offer abundant opportunities to study and compare methods. Large-scale manufacture of munitions has tremendously increased the hazards to the workers in that field. The author has assembled and made intelligently critical comment on all available literature so that those who deal with bones and joints and industrial diseases must possess this book.

Food, by Frank A. Pearson and Don Parrlberg ($2.75, *Alfred A. Knopf, New York City)* is wrtiten by this well-known professor of prices at Cornell University and his assistant. The authors are not alarmed about the food shortage and offer as a solution for this problem the increased use of cereal grains as food for man. It is questionable whether many of us physicians would care to see this carried to the place where our people have inadequate amounts of meat, milk, and eggs to supply them with protein of high quality. Most of us feel that such proteins are essential in the production of immune antibodies and our consequent resistance to infections. They likewise offer for the tangle of roll-backs, subsidies, price-fixing, and black markets, a return to the price system which the authors contend would inevitably guide the production, distribution, and consumption of food into those channels which would be for the best interests of the nation. While none of us are experts in this field, this solution appeals mightily to our emotional background.

New and Non-Official Remedies, (1943, *American Medical Association, Chicago*) contains description of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1943. It is an exceedingly valuable book, as most physicians well know.

The Ohio State Medical Journal

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JONATHAN FORMAN, M.D., *Editor*

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Radiology and The Law

S. W. DONALDSON, M.D.

THE medico-legal aspects of the practice of radiology are becoming of more importance as the specialty increases in its scope in the practice of medicine. The practice of radiology is considered as the practice of medicine and is governed by the same statutes and legal opinions. The legal opinions pertaining to the practice of medicine may vary slightly in various states but the consensus is about the same all over the country.

DEFINITION

A medical practitioner in general is described and understood as being one who is lawfully engaged in the practice of medicine or surgery and who holds himself out as being able to diagnose, treat, operate upon or prescribe for any human disease, pain, infirmity, injury, deformity, or physical condition.

In general he does not belong to any particular school, but some states stipulate exceptions to the methods and means of treatment to be used. However, it may be said that in a malpractice action against a physician, the general rule is that the physician is entitled to have his treatment of his patient tested by the rules and principles of the school of medicine to which he belongs, and not by those of some other school. A person professing to follow one system or school of medicine cannot be expected to practice any other, and if he treats a patient with ordinary skill and care in accordance with his system, he is not answerable for bad results. (Wemmett vs. Mount, Ore., 292, P. 93.)

Internists, otologists, roentgenologists, and other specialized branches are defined as devoting special study to their respective branches in medicine. In the eyes of the law each is bound to the common rule that he be required to bestow such reasonable and ordinary care, skill and diligence as physicians and surgeons in the same neighborhood, in the same general line of practice, ordinarily have and exercise in like cases. (Czajka v. Sandowski, Mich., 219 N.W., 660.)

The physician is not an insurer and cannot be held liable for a bad result unless proof of negligence is produced. In the case of Evans v. Clapp (Mo. App. 1921), 231 W.W. 79, it was said, "The standard of care in the use of X-ray machine must be derived from among the users thereof, and the term 'similar localities' must in this connection have a somewhat general and relative meaning," but the Supreme Court of New York in 1918 says, "In the case of a specialist the standard would be ordinarily that possessed by practitioners devoting special attention and study to the same branch in similar localities, having regard to the present state of medical science," and determining the degree of skill required, it is stated in Pike v. Honsinger (1898), 155 N.Y. 201, 210, that "he is bound to keep abreast of the times".

Therefore, there can be no urban and rural rule for the use of X-ray as there is for the general practitioner, who is negligent if he does not use the care and skill of the community. X-ray

The Author

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is not used under circumstances of emergency as other measures sometimes are, so a higher standard is possible in this field.

LEGAL REQUIREMENTS

The law, having stipulated the compulsory progress of requiring the physician to keep abreast of the times, does go one step farther and say that he shall not go beyond the accepted methods of modern practice unless "he is prepared to take the risk of establishing by his success the propriety and safety of his experiment".

Whenever any hazard exists, one can always find some form of insurance to cover it. Insurance exists which is protection for malpractice claims against the general practitioner and specialist, but the higher rate for those engaged in X-ray work, and especially in treatment, is in itself evidence that this method of diagnosis and treatment embodies hazards more severe than in any other branch of medical science.

The medico-legal side of the use of X-rays has three main divisions, namely: (1) Liability arising out of the use of X-ray, either for diagnostic or therapeutic purposes, (2) Liability arising out of the failure to use X-ray and (3) the use of X-ray plates or films as evidence.[2] The risks encountered by the radiologist or the physician who owns and operates an X-ray machine cover a wide scope but may be divided into two classes—personal and legal. Those in the personal class have to do directly with the patient, such as over-exposure, insufficient protection, injuries resulting from mechanical defects in the machine, incomplete or inaccurate records, and after-care of the patient. The legal hazards are more or less predetermined by statutory laws or decisions of the courts: if the physician fails to meet the requirements as already set forth, then he may, according to the law, be held liable.

MALPRACTICE

Most malpractice claims fall under the head of negligence, but there are three other sources of liability which must be considered: (a) cases in which the operator of the X-ray machine guarantees no harm, (b) the fact that the X-ray is inherently a dangerous agent, and (c) electrocution from high tension current. None of these three should ever be the cause of any suit brought against a well-trained radiologist.

As stated, most malpractice suits are based on negligence and allege that the physician failed to comply with his implied contract or with one set up by statutory law. For example, the allegation may be a want of professional skill or knowledge, or, on the other hand, negligence in not applying the skill or knowledge possessed. A physician may also be sued for malpractice because of the acts of his assistants or employees.

In a malpractice action in which there is a claim of negligence, the burden of proof is upon the plaintiff. Thus in Goode v. Lothrop, 165 N.E. 688, the Supreme Judicial Court of Massachusetts said, "The burden was on the plaintiff to show acts of negligence or acts from which negligence could properly be inferred." He must prove that a contractual relationship existed between the physician and the patient, and that the physician departed from the path of his duty, and that this departure was the cause of the injury claimed. These allegations must be proved by a preponderance of evidence (48 C.J. 1143-44) and, it must be noted, the charge of negligence in medical practice demands proof by medical testimony, (48 C.J. 1150). A layman cannot testify as to what constitutes such negligence.

EXPERT TESTIMONY

Expert testimony is not, however, the only means by which a physician's negligence can be established. In holding that there was no error in the lower court's instructions to the jury, the Springfield (Missouri) Court of Appeals in Seewald v. Gentry, 286 S.W. 445, said "that proof of negligence need not be by direct testimony, but may be inferred by the jury from all the facts and circumstances in evidence in the case".

Absolute certainty that the injury resulted from negligence is not required, proof which satisfies the jury's mind to reasonable certainty being sufficient. And it may be said here that any admission on the part of the physician which may be interpreted by the patient or jury as implying that the injury was the result of some error in technique may be this sufficient proof.

In some instances the presence of damage to the skin and underlying tissues has been satisfactory evidence that negligence did exist, the rule evidently being that proper equipment properly used produces no untoward result; in other words, "the thing speaks for itself" principle having been applied.

A ruling of this principle of *res ipsa loquitor* contrary to the weight of opinion is given in the Minnesota case of Holt v. Ten Broeck (1916) 134 Minn. 458, 159 N.W. 1073, Ann. Cas. 1918 E 256. This is a jurisdiction that permits the jury to draw an inference of negligence in such cases, to consider and weigh the inference in the light of the facts and circumstances, and to give it such weight as they deem it entitled to in proving negligence. The Supreme Court of Minnesota said in the case of Sawyer v. Berthold, 116 Minn. 441, 134 N.W. 120, "It is undoubtedly correct that negligence of a physician or surgeon cannot be inferred from a poor result alone. There must be evidence from expert witnesses to show improper and unskillful treatment in order to sustain a charge of malpractice".

Unusual sensitiveness, idiosyncracy to X-ray, and similar conditions have not been scientifically demonstrated and can not be determined before-

hand by any known methods.[3] In Antowill v. Friedman, 197 App. Div. 230, 188 N.Y. 777, the court recognizes the condition of hypersensitivity, "it having been proven that that specific result might come from proper treatment without negligence . . . that is, in the case of a hypersensitive person".

Liability growing out of the use of X-ray for diagnostic purposes is now rare and should be unknown with the present-day high milliamperage technique and high-speed screens and films. The same situation exists in regard to prolonged fluoroscopy in the hands of competently trained men who know of the dangers. But unfortunately all patients who are subjected to fluoroscopy for reduction of fractures, removal of foreign bodies, or the introduction of contrast media do not fall into the hands of those men who know when to quit.

The general practitioner or surgeon may indirectly be involved in claims based upon X-ray examinations in that he did not use the roentgen ray as a clincal facility in order to establish a correct diagnosis. Opinions may be found which are at variance on whether or not negligence exists for failure to use the X-ray. In Wright v. Conway, 241 Pac. 369, the Supreme Court of Wyoming said, "The failure to use X-ray, even though available, is not necessarily held to be negligence."

In Stoll v. Balazs, 32 Ohio App. 117, 167 N.E. 522, the Court of Appeals in affirming the judgment of the lower court said, ". . . we can come to no other conclusion than that the jury was justified in finding a verdict against the attending physician, and we think the evidence is ample in the record that he did not use the usual and recognized methods of determining just how this bone could be set". Experts had, in this case, testified that it was customary and usual to use the X-ray in the reduction of fractures of bones of the limbs.

LAW OF AGENCY

The law of agency can be applied to the radiologist from many different angles. Technicians either in his employ or paid by the institution in which he practices, work under his direction and are his agents. Typists, internes and nurses are delegated a certain amount of responsible duties to perform for which the radiologist is responsible in the eyes of the law. Internes are exempt in some states from the provisions of the medical practice act while performing duties for a hospital.

The principal-and-agent relationship is also established between the radiologist and the hospital with which he is connected, but to attempt to lay down a general rule as to whether or not a hospital is liable for the negligence of its physician-employee is not possible in view of the many widely differing decisions of our courts. Further it may be said that the radiologist does not enjoy immunity if he is connected with a charitable institution.

The radiologist is frequently called into court to give expert testimony upon films, but it is also a common practice to have the films identified and then to question the attending physician regarding their interpretation, irrespective of whether or not he has any special knowledge of the significance of the shadows. Several decisions have been handed down in which it was made unmistakably clear that the court errs in allowing laymen, technicians and others to read into films evidence which is not there and which facts can not be discerned by the ordinary jury, as if the so-called "picture" were a photograph.

Some jurists recognize the fact that introduction of such evidence is not proper and have expressed themselves in regard to their own courts that they care little or nothing for the exhibition of the films, but rely upon expert testimony in the form of either written or verbal interpretation. That is, the film in itself means little, but its interpretation by an expert who has had years of training and experience in reading similar films is the important thing to consider.

Apparently, the courts transferred bodily to radiographs the rules that were considered applicable to photographs, and the general tendency to regard them as secondary evidence has since been fairly consistent.

STATUS OF PHOTOGRAPHY

Photographs usually are competent evidence in that they help the jury understand the situation better than it could if the conditions were described by the oral testimony of the witnesses. However, in Ligon v. Allen (1914) 157 Ky. 101, 162 S.W. 536, 51 L.R.A. (N.S.) 842, it is said: "If no witness has thus attached his credit to the photograph then it would not come in at all any more than an anonymous letter should be received as testimony."

In so far as their credibility is concerned, photographs have the same status as maps and diagrams. A photograph may be admitted in evidence if a person familiar with the facts portrayed by it testifies that the picture is correct; or, if it is proved that the process which produced it is accurate and gives correct pictorial results.

The rule appears briefly to be: a photograph becomes admissible if its correctness and accuracy (or reasonable accuracy to inform the jury) have been proved, assuming that all basic precautionary rules of evidence have been applied. This is best stated in Higgs v. Minneapolis, St.. P. & S. St. M. Ry. Co. (1908), 16 N.D. 446, 114 N.W. 722, wherein the court said, "It can not be disputed that the photograph rests upon human testimony as to its correctness, and unverified

carries no conviction as to its correctness." A radiograph to be admitted as evidence must be verified and the court must be satisfied that it represents a person or thing material to the case.

In Bartlesville Zinc Co. v. Fisher, 60 Okla. 139, 159 Pac. 476, it is stated, "the plates were not admissible in evidence, nor could they be until they were properly identified . . .". In Demopolis Telephone Co. v. Hood, 102 So. 35, the court takes cognizance of identifying data upon the films and says, "the taker of the roentgenogram testified to an identifying number, placed by him on it, with the date. The roentgenogram was made a part of the record. An examination disclosed the number 490, and 6-4-23 standing for June 4, 1923. These marks in connection with the testimony, were sufficient on the question of identification".

PRIVILEGED COMMUNICATION

The privileged communications rule is mandatory—it does not give the physician the right to elect whether or not he will disclose information—and recognizes no distinction between patients. It has been definitely decided that a free patient is as much entitled to the full protection of the statute as the patient who pays for the professional services rendered to him. Bauch v. Schultz (N.Y.) 109 Misc. 548. In Stapleton v. Chicago, Burlington and Qunincy R. Co. (Neb.) 162 N.W. 644, the Supreme Court of Nebraska handed down the following interpretation of the privileged communications section of the statutes of the State of Nebraska, "The same rule which would exclude the oral testimony of the doctor would exclude the radiographs of the plaintiff's foot. Its introduction in evidence would be a disclosure of a confidential communication."[4]

Much has been said and written about the ownership of the roentgenogram. While not fully to the point it has been indicated that photographs belong to the photographer. Whipple v. Grandchamp (Mass.) 158 N.E. 270, was the earliest of the decisions relating to the ownership of X-ray films. The decision of greatest interest to the radiologist is a decision of the Michigan Supreme Court, McGarry v. J. A. Mercier Co., 272 Mich. 501, 262 N.W. 296, rendered in 1935. In this case it was held that "In the absence of agreement to the contrary, such negatives are the property of the physician or surgeon who has made them incident to treating a patient . . . they are as much a part of the history of the case as any other case record made by a physician or surgeon."[5]

The radiologist is most often called upon to give medical testimony based upon roentgen findings in injury cases in which there is a claim of impaired function, with or without skeletal damage. Expert testimony is essential in such cases, for where a case concerns a highly specialized art with respect to which the layman can have no knowledge at all, the court and jury must be dependent upon the testimony of those competent to give opinions in regard to such an art or science.

REFUSAL TO TESTIFY

In some jurisdictions the refusal of the witness to testify unless paid an extra compensation has been declared punishable as a contempt of court. In other jurisdictions, a statute grants the court a discretionary power to allow fees to experts that are just and reasonable. In the absence of a statute to the contrary, an expert may with propriety contract for extra compensation, but the law may only permit litigants to agree to pay extra compensation for an expert testimony subject to the limitations set by the court. People v. Cowles, 246 Mich. 429, 224 N.W. 387. Before obligating oneself to appear as an expert, some definite agreement as to the fee should be made.

Many physicians are loathe to appear in court as either an ordinary witness or to give opinion testimony. The principal reason perhaps is that they are subject to cross-examination which sometimes seems to question their honesty and integrity if the opposing counsel resorts to insinuations and sarcasm in an attempt to influence the jury adversely as to the competency of the witness.

If you have never appeared as a witness it is advisable that you attend a few trials in order to familiarize yourself with court-room procedure. Before appearing as a witness in a case, go over the history and all findings carefully. Be prepared and do not rely upon your memory as you are allowed to refer to any notes or records you may have. Answer each question in simple terms and do not volunteer testimony. Tell the truth, the whole truth and nothing but the truth and then there is no ordeal to occupying the witness stand.

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Other common and unnecessary skin rashes are due to the use of phenol in lotions and ointments. It is a common practice in industrial first-aid offices, to apply calamine lotion or ointment to many itching eruptions. The nurse, doctor, or patient then bandages the part and the patient returns to work.—George E. Morris, M.D., Boston, Mass.; Ind. Med., Vol. 13, No. 5, May, 1944.

The Incidence of Hypothyroidism

RALPH M. WATKINS, M.D.

THE state of lowered metabolism as measured by one of the standard means is a very frequent occurrence in the experience of any physician who is engaged in observing patients with medical derangements. In fact, the condition is experienced often by those doctors who are specialists in lines but little related to internal medicine. The subject has been of great interest to us for a number of years and has been responsible for two previous publications.[1,2]

We have reviewed the records of 706 patients in connection with whose examinations, basal metabolism estimations were made. The tests all were done in the office laboratory using metabolors made by one company and nearly all of the tests were carried out by one of three technicians who have been in our employ during the last 13 years. This represents an average of more than one patient per week for whom it was thought necessary to determine the metabolic rate. All of us know that so-called "complete" examinations in the hospital and in the office are carried out differently. In the hospital where, in these days, so many laboratory procedures are included in blanket rates or flat rates or paid for by insurance protection, there is a great tendency for the doctor in charge to order to be done a mass of laboratory tests, many of which are not indicated and, indeed, uncalled for. Perhaps the thought is that nothing, however remote, should be overlooked. It is painful to admit that much of the work is superfluous. In office examinations the contrary principle holds. Undoubtedly routine urinalyses, blood counts and serological tests are done for nearly all new patients but the special tests such an X-ray examinations, blood chemistry and basal metabolism tests are much more likely to be carried out only if something reasonably definite points to the need of them. One wishes to spare the patient unnecessary cost.

The point of the above remarks is that, if more than one patient per week, as seen in the office, requires a metabolism test, then physical indications of deranged metabolism are very common.

The above figure of 706 represents individual patients and not repetition of tests. The number of basal metabolism tests done for these 706 patients must be two thousand or more. We have not added them up but many patients have had more than one test, some as high as 15 over this period of years.

TECHNIQUE OF TESTING

The technic of the testing is worth a note. It may be necessary to do several tracings to secure a satisfactory one, but these are all counted as only one test. If two or three tests are done on successive days they are counted as one test. Some days or weeks or months must elapse before another estimation is called, a second, or follow-up test.

If the basal metabolic rate is found to be minus 10, or below that, the case is considered as one of hypometabolism, cause to be discovered. It usually falls into the disease classification of hypothyroidism as noted in a previous paper.[1] In the minority of cases the hypometabolism may be a sign of such disease as one of the types of malignant neoplasm, various anemias, chronic wasting infections or degenerative disease. Also with what we may call true hypothyroidism there may be associated derangements, such as disorders of other endocrine glands, which is very common and, in fact, to at least a slight extent, is true in all cases of hypothyroidism. It is doubtful if there is such an entity as a pure single endocrine gland disorder of function. Then, also, ailments of other parts of the body and of other organs are frequently found along with hypothyroidism. So many cases are of middle life that it is not at all remarkable that common diseases of that period, such as gall bladder disorder, early cardiovascular changes, arthritis, and so forth, occur with frequency.

FREQUENCY OF HYPOTHYROIDISM

At this point, let us lay a bit more stress on the commonness of hypothyroidism. We stated above that in 13 years, we had performed basal metabolism tests on 706 patients. This does not mean that all had hypothyroidism, a few had high metabolic rates, more fell within normal ranges but, of the group, 408 had low metabolic readings, from minus 10 down. Many tests were done by our laboratory for other doctors. As a general rule these patients were tested once only so that it is impossible to make any diagnosis in those instances. However, we do have complete records: case histories, physical examinations, laboratory tests and follow-up records of our personal cases which numbered 234 of the larger group.

These 234 hypothyroid cases were found and diagnosed in the period of time in which about 3,500 new cases were seen in the office. These

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3,500 people had all sorts of diseases which could be classified under the heading of internal medicine. Therefore, in our own practice, we have encountered hypothyroidism in 6.7 per cent or one in each 16 patients. There are not many diseases as common as that. In a practice which is general and which includes surgery, obstetrics, etc., the percentage would not be so high; nor, of course, in certain specialties; but it must be admitted that it is a very common disease, even though those of us in internal medicine have a greater opportunity to meet it than if we were in some other department of medicine.

THE CLINICAL PICTURE

Being such a common disease does not mean there is any narrow train of symptoms which characterize it. Rather, they are protean. It may be worth while to mention these briefly:

Weakness is common, a feeling of muscular fatigue on exertion, or muscle tiredness at the end of the day with aching and, not infrequently, muscle cramps; the patients have plenty of desire to do things, but their objectives seem hard to attain; it seems that too much energy is needed, and is more than they have; they usually have a good intelligence yet suffer from mental laziness; it tires them to have to use their minds; they are inclined to become sleepy if reading or engaged in monotonous activities.

They are happy to sit and relax, they often put off doing things which they can easily postpone; or, if they do them, they carry them out with no signs of pleasure of accomplishment; they are nervous, yet are not of the highly-tensed type; instead, they seem nervous largely because of things undone and which they worry about doing; ordinarily, they are good sleepers, often they sleep too much, and many of them wish they could take naps in the daytime; a small minority have insomnia, at least they so state; many are overweight, some are of normal weight, a few are thin, but it is a general rule that the obese ones all complain of how difficult it is for them to lose weight short of very rigid dieting.

Women have menstrual disturbances, usually scanty flow; sometimes the menopause comes early in their lives and they may have some of the unpleasant symptoms of that time; constipation is fairly common, yet the digestion is usually good and the appetite also, unless they have organic disease of the gastrointestinal tract; loss of libido occurs; headaches are common; arthritis, especially the hypertrophic form, often is seen and therefore all types of rheumatic complaints are voiced.

On physical examination one will find the typical patient to be a woman who looks older than her actual years. This may be because of the skin changes that occur; the skin is dry, loses its color and its appearance of vigor, and wrinkles occur earlier than they should; in real myxedema the face is characteristic but one hardly ever sees that disease; on the other hand we often see some heaviness and puffiness of the features; the hair is dry and loses its sheen; the nails often are cut short because they crack and peel in surface layers; many blame nail polish when it actually is their hypothyroid state which is responsible.

Many of the patients are overweight but often not much; instead they are rather pudgy with the fat well distributed, with thick wrists and ankles and neck, as well as prominent breasts, abdomens, and hips; the thyroid may be enlarged but usually is not; the blood pressure will be normal, or low normal, or, occasionally, too high or too low; the pulse is slow and the heart sounds not too sharp; there may be other abnormalities but these are the main ones. About 10 per cent of the cases fall into the wasted class; these people are too thin and one would do well to recall that this disease does occasionally occur in thin persons.

As suggested above, the majority of the patients are female. In the 408 patients whose metabolism records we have there were 100 males and 308 females.

The disease is most noted between the ages of 30 and 50. There were 3 patients under 10, 31 between 11 and 20 years; 60 between 21 and 30; 125 between 31 and 40; 111 between 41 and 50; 56 between 51 and 60; and only 24 over 60, when first examined by us.

TREATMENT AND RESULTS

Treatment is almost universally satisfactory. It would seem that people should be happy to have such an ailment which responds so well to the specific medication which can be taken by mouth at a certain time daily. Many patients cooperate well and carry on their treatment indefinitely, believing the statement made that, more than likely, they must continue it the rest of their lives. But for some it seems too simple; so much so, that they forget it easily; they are apathetic, anyhow, and perhaps should rather be pitied than blamed. Therefore, they lapse. In a few cases thyroid extract disagrees; they develop palpitation and nervousness. A change of brand or the use of thyroxin may help there.

We like to start with small doses and build them up to need instead of giving a huge dose at first to get quick response and then lowering it. The small dose method takes longer; the patients respond more slowly, but there is less danger of starting activity in an adenoma which could not be found at examination. Patients should be interviewed frequently at first and their appearance, heart action, blood pressure and weight watched for any signs of over activity of the thyroid. The basal metabolic

rate should be checked occasionally. After the proper dosage is determined these people should be asked to report once in several weeks or even months. Some we see only two or three times a year, and a few of these take large doses of thyroid, five or more grains a day.

We have no cretins under treatment. We see a few cases of real myxedema; that is an uncommon disease.

Of the 234 cases from our personal files, the great majority are doing well under treatment.

BLOOD CHOLESTEROL FINDINGS

Recently we have been interested in the relationship between hypothyroid states and the whole blood cholesterol. We have therefore tested the latter at the time of testing the metabolic rate in the last 23 cases. By our method, reading between 140 and 180 mg. cholesterol per 100 cc. whole blood are considered within normal limits. The results follow:

Sex	Age	B.M.R.	Cholesterol
F	16	—26	196
F	26	—13	171
F	29	—16	185
M	31	—16	185
F	37	—28	195
F	38	—17	195
F	38	—21	235
F	38	—10	165
M	39	—28	190
F	39	—27	196
F	40	—11	196
M	41	—10	209
M	45	—24	209
F	45	—21	202
F	49	—25	205
M	50	—15	185
F	51	—10	238
F	52	—16	196
M	60	—14	230
M	60	—10	197
F	61	—19	230

It may be seen that, whereas, in general, the blood cholesterol readings are elevated, there is no direct relationship between them and the degree of hypothyroidism, or the age, or sex.

SUMMARY

1. We have tested the basal metabolic rate of 706 patients. Of these, 408 registered minus 10 or below.

2. Of the latter, 234 are personal patients of whom we have complete records.

3. These 234 patients with hypothyroidism represent 6.8 per cent of the total patients seen over a period of time in a practice limited to internal medicine. Therefore, the disease must be very common and should be watched for.

4. The clinical picture is briefly described.

5. Treatment is reviewed and results noted.

6. A small series of whole blood cholesterol readings in hypothyroidism shows them to be elevated but not in direct relation to intensity of disease, or to age or to sex.

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Untoward Reactions to Liver Extract

Most of the investigators stress the very small number of after-effects following liver extract injections. However, as time goes on and the use of liver extract becomes more popular, reports on untoward reactions will be forthcoming more frequently.

Some authors reported cases which developed angioneurotic edemas, urticarias, generalized erythema, attacks of bronchial asthma, sudden weakness (fainting, sweating, diarrhea, dyspnea) pruritus, uterine bleeding, etc. A fixed eruption following the injection of crude liver extract was observed. The same author tells of his experience with a case of mycosis fungoides, in which a flare-up of the lesions occurred each time after an injection of liver extract. Some authors speak of moderate pain following the injection of liver. In some cases the local reaction lasted for almost one week. A case is also mentioned of a patient who had no trouble with one kind of liver extract but when another form was used a severe urticaria developed.

It is believed that "there are two types of reactions, one of an allergic nature, the other probably attributable to vasodepressor substances not well defined chemically."

Most of my patients tolerated the injections of liver extract except for slight and transient pain and discomfort at the site of the injection.

It is noteworthy that four of the patients who were pregnant received the antisyphilitic therapy concurently with liver extract without any ill effect on either the patients or the course of their pregnancies.

However, five of my patients developed untoward reactions which are noteworthy. One patient developed nausea after each injection of liver. It had to be discontinued. Another patient, following an injection of 3 cc. of liver extract, complained of sudden dizziness, weakness, tendency to faint, and pain in the left side of chest. The patient recovered in five minutes. A week later he received a smaller dosage of liver extract without any after-effects, and continued to receive weekly injections in gradually ascending dosages without any reaction. A third patient who tolerated crude liver extract developed palpitation of the heart and general weakness when another form of liver extract was given by mistake, and the last patient complained each time of a very severe local pain lasting more than twenty-four hours, following the intramuscular injection. Because of that the intravenous method of administration was instituted in this case.—Girsch D. Astrachan, M.D., New York City; New York State Journal of Medicine, Vol. 44, No. 9, May 1, 1944.

Dark Adaptation in Skin Conditions

J. D. WALTERS, M.D.

ONE of the methods of determining vitamin A deficiencies has been by the use of physical apparati, such as the biophotometer, adaptometer, and viconometer.[1] In conducting the following series of tests the Feldman Adaptometer was used. It has been considered that normal individuals will show a recovery period of less than five minutes after a three-minute exposure to light of a definite intensity. After performing these tests on 646 patients with varied skin conditions, it has been found that 24 per cent of these showed normal readings. For an analysis of this 24 per cent see Table I. For a detailed analysis of all findings, refer to Table V.

The Author

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TABLE I

Diagnosis	Below 5 Minutes	5 to 18 Minutes	Total
Acne Vulgaris	37	71	108
Alopecia Areata	5	11	16
Alopecia Totalis	1	2	3
Atopic Dermatitis	26	62	88
Eczema, Numular	21	24	45
Erythema Multiforme	1	2	3
Granuloma Annulare	1	0	1
Herpes Zoster	3	2	5
Infectious Eczematoid Dermatitis	3	20	23
Keratoses and Callosities	1	8	9
Lichen Planus	2	9	11
Lues (Congenital)	0	4	4
Lues (Latent)	4	11	15
Lues (Tabes)	0	5	5
Lupus Erythematosis	1	3	4
Nail Dystrophies	1	8	9
Nevi (Pigmented)	1	7	8
Pellagra	2	14	16
Pityriasis Rosea	2	7	9
Pruritus Ani	2	11	13
Pruritus Ani et Vulvae	0	11	11
Pruritus Ani et Scrotum	0	5	5
Pruritus (Generalized)	3	17	20
Psoriasis	8	17	25
Scleroderma	2	1	3
Seborrhoeic Dermatitis	4	32	36
Tinea Cruris	2	2	4
Tinea, Toes (Infectious)	1	12	13
Tinea Versicolor	1	2	3
Urticaria	1	8	9
Varicose Ulcers (leg)	1	3	4
Verruca Vulgaris	8	26	34
Vesicular and Bullous Eruptions (hands)	6	57	63
Vitiligo	3	5	8
Xanthelasma	1	2	3

TABLE II

Diagnosis	Time Interval For Recovery Period. Minutes	Vitamin A Level In Blood. Micrograms Per Cent
Vesicular Eruption (hands)	3½	125
Verruca Vulgaris	6	97
Infectious Eczematoid Dermatitis	3	120
Urticaria	9	196
Eczema (external ears)	6	100
Verruca Vulgaris	3½	130
Pruritus Ani	8	180
Infectious Eczematoid Dermatitis (hands)	9	220
Infectious Eczematoid Dermatitis	7	200
Atopic Dermatitis	7	165
Lues (latent)	7	180
Capillaritis	5	280
Urticaria	3	270
Atopic Dermatitis	9	250
Seborrhoeic Dermatitis	8½	245
Atopic Dermatitis	5½	170
Verruca Vulgaris	6	90
Atopic Dermatitis	7	200
Pruritus Vulvae	4	270
Eczema	9	260
Seborrhoeic Dermatitis	8	240

The normal level of vitamin A in the blood is at least 75 micrograms per cent.

TABLE III

Diagnosis	Recovery Time Interval. Minutes	Vitamin C Levels. Micrograms Per Cent
Eczema	3½	0.83
Verrucae Vulgaris	3½	0.90
Urticaria	9	1.8
Seborrhoeic Dermatitis	8	1.3
Eczema	3	0.90
Pruritus Vulvae	8	1.4
Atopic Dermatitis	5½	1.6
Eczema	9	1.4
Infectious Eczematoid Dermatitis	7	1.8
Atopic Dermatitis	7	1.2
Erythema Multiforme	5	0.79
Eczema	3	0.70
Pruritus Ani	4	0.84
Seborrhoeic Dermatitis	6	1.8
Infectious Eczematoid Dermatitis	9	1.9
Alopecia Areata	8	1.5
Atopic Dermatitis	7	1.2
Atopic Dermatitis	9	1.1
Atopic Dermatitis	5	1.6
Pruritus (Generalized)	3	1.4
Seborrhoeic Dermatitis	2	1.7
Erythema Multiforme	6	0.92
Seborrhoeic Dermatitis	6½	0.94
Eczema	7	0.98
Atopic Dermatitis	7	0.87
Eczema	7½	0.84
Acne Vulgaris	6	0.90

Normal levels of vitamin C by Farmer and Abt are a minimum of 0.5 micrograms per cent.

Following are the determinations of adaptation recordings on a large group of successive dermatological cases as seen in the office. It is interesting to note that 24 per cent were in the normal range.

TABLE V
Chart of Skin Conditions and Dark Adaptation Findings

Diagnosis	1-2 Min.	2½-3½ Min.	4-5 Min.	5½-6½ Min.	7-8 Min.	8½-9½ Min.	10-12 Min.	12-14 Min.	15-18 Min.
Acne Vulgaris	11	6	20	30	30	4	5	2	0
Alopecia Areata	2	0	3	3	6	1	0	1	0
Alopecia Totalis	0	1	0	0	0	1	1	0	0
Atopic Dermatitis	6	5	13	18	30	7	5	2	0
Capillaritis	0	0	0	1	0	0	0	0	0
Carbuncles	0	0	0	0	0	1	0	0	0
Darrier's Disease	0	0	0	0	1	0	0	0	0
Duhring's Disease	0	0	0	1	0	0	0	0	0
Eczema (External Ears, Eyelids, Neck) and Numular	8	2	11	6	17	0	0	0	1
Erythema Multiforme	0	0	1	0	2	0	0	0	0
Erythema Nodosum	0	0	0	0	1	0	0	0	0
Frostbite	0	0	0	1	0	0	0	0	0
Granuloma Annulare	0	0	1	0	0	0	0	0	0
Herpes Zoster	1	0	2	0	2	0	0	0	0
Keratoses and Callosities	1	0	0	4	0	4	0	0	0
*Infectious Eczematoid Dermatitis	0	1	2	2	9	3	2	4	0
Lichen Planus	1	0	1	0	5	0	2	2	0
Lues (Congenital)	0	0	0	2	1	1	0	0	0
Lues (Latent)	0	1	3	5	6	0	0	0	0
Lues (Tabes)	0	0	0	1	2	1	0	1	0
Lupus Erythematosis	0	0	1	2	1	0	0	0	0
Nail Dystrophies	0	0	1	3	4	1	1	0	0
Neurofibromatosis (Generalized)	0	0	0	1	0	0	0	0	0
Nevi (Pigmented)	0	0	1	1	3	0	3	2	0
Paronychia	0	0	0	0	1	0	0	0	0
Pellagra	1	0	1	4	5	3	2	0	0
Pemphigus Vulgaris	0	0	0	1	2	0	0	0	0
Pityriasis Rosea	1	0	1	3	3	1	0	0	0
Pruritus Ani	1	0	1	5	5	1	0	0	0
Pruritus Ani et Vulvae	0	0	0	2	8	0	1	0	0
Pruritus Vulvae	0	0	0	0	2	0	1	0	0
Pruritus Ani et Scrotum	0	0	0	2	2	1	0	0	0
Pruritus Scrotum	0	0	0	0	1	0	0	0	0
Pruritus (Sweat)	0	0	0	2	1	0	0	0	0
Pruritus (Generalized)	1	0	2	6	4	2	1	3	1
Psoriasis	1	1	6	4	12	0	0	1	0
Scleroderma	2	0	0	0	1	0	0	0	0
Seborrhoeic Dermatitis	2	1	11	1	15	1	3	1	0
Sycosis Vulgaris	0	0	0	0	1	0	0	0	0
Tinea Circinata	0	0	0	0	1	0	0	0	0
Tinea Cruris	0	1	1	0	2	0	0	0	0
Tinea, Toes (Infectious)	0	0	1	3	7	1	1	0	0
Tinea Versicolor	1	0	0	2	0	0	0	0	0
Urticara (acute & chronic)	0	0	1	5	1	1	1	0	0
Varicous Ulcers (leg)	0	1	0	1	0	0	1	1	0
Verruca Vulgaris	1	1	6	10	10	1	2	3	0
Vesicular & Bullous Eruption, non-myotic (hands & feet)	2	2	2	10	26	9	9	3	0
Vitiligo	2	0	1	0	2	2	0	1	0
Xanthelasma	1	0	0	1	1	0	0	0	0

*This group includes occupational dermatoses, contacts with nail polish, perfumes, cosmetics, etc.

Twenty-one cases were selected at random. On these, both the blood chemical analyses of vitamin A levels[2] and adaptometer tests were performed. There was no vitamin A deficiency apparent in any of these cases employing the photovolt photo-electric colorimetry tests,*[1] yet 15 of these 21 cases showed abnormal adaptometer recordings. Table II illustrates the results on the 21 cases, using both the Feldman adaptometer and the photovolt photo-electric readings.

In patients where abnormal adaptometer readings were obtained, riboflavin, vitamin C, and vitamin D were added to their diet since a clinical trial of vitamin A for a period of six months to one year had showed little or no improvement in adaptometer recordings. It has been observed that there may be some connection between these abnormal findings and deficiencies of riboflavin, ascorbic acid, and vitamin D. In a series of 27 unselected cases, vitamin C chemical analyses[3] were performed according to the photovolt colorimetric method. All findings of vitamin C were normal, although adaptometer readings were abnormal in 9 cases. See Table III for a complete analysis of these readings.

*1 The chemical determinations of Vitamin A, as reported in Table II and IV, were performed by the photovolt, photoelectric colorimetric method with the use of antimony trichloride reagents.

SUMMARY

The total of 646 dark adaptometer recordings were made using the Feldman adaptometer. Forty-nine different dermatological problems were represented in this group. One hundred sixty-five recordings were within the normal range and practically each group with the exception of congenital lues, tabes, pemphigus vulgaris, pruritus ani et vulvae, pruritus ani et scrotum and sweat pruritus, showed some normal recordings. See Table V for a complete analysis of these recordings.

Normal readings were present in many patients with skin conditions which heretofore have been considered by many as a manifestation of Vitamin A deficiency. Blood levels of Vitamin A were taken in 21 cases selected at random. Likewise, blood levels of Vitamin C were taken in 27 patients selected at random. Dark adaptation

TABLE IV

Comparison of Vitamin A and C, and Adaptation Levels In a Group of Patients

Diagnosis	Recovery Time Period. Minutes	Vitamin A Level. *mgms. %	Vitamin C Level. *mgms. %
Eczema	3½	125	0.83
Verruca Vulgaris	3½	130	0.80
Eczema	3	120	0.90
Urticaria	9	196	1.8
Pruritus Vulvae	8	180	1.4
Atopic Dermatitis	5½	170	1.6
Seborrhoeic Dermatitis	8½	245	
Eczema	9	260	
Eczema	9	220	1.4
Atopic Dermatitis	9	250	
Capillaritis	5	280	
Urticaria	3	270	
Pruritus Vulvae	4	270	
Atopic Dermatitis	7½	165	
Lues (Latent)	7	180	
Seborrhoeic Dermatitis	8	240	
Infectious Eczematoid Dermatitis	7	200	1.8
Atopic Dermatitis	7	200	1.2
Verruca Vulgaris	6	97	
Eczema	6	100	
Erythemia Multiforme	5		0.79
Verruca Vulgaris	6	90	
Eczema	3		0.70
Pruritus Ani	4		0.84
Seborrhoeic Dermatitis	8		1.3
Infectious Eczematoid Dermatitis	9		1.6
Atopic Dermatitis	7		1.2
Alopecia Areata	8		1.1
Seborrhoeic Dermatitis	6		1.8
Atopic Dermatitis	9		1.5
Pruritus (Generalized)	3		1.4
Atopic Dermatitis	5		1.6
Seborrhoeic Dermatitis	2		1.7
Erythema Multiforme	6		0.92
Seborrhoeic Dermatitis	6½		0.94
Eczema	7		0.98
Atopic Dermatitis	7		0.87
Eczema	7½		0.84
Acne Vulgaris	6		0.90

*mgms. % is the abbreviation for micrograms per cent.

tests were taken in both of the latter groups. Although some adaptation readings were abnormal, there were no abnormalities in the Vitamin A or Vitamin C levels as determined by the blood levels in these two groups as shown in Tables II, III, and IV.

CONCLUSION

From this analysis it is noted that the dark adaptation tests should not be considered as specific for a Vitamin A deficiency. When an abnormal range is present, it is a further indication to study the blood picture, to analyze the patient's diet and habits, and check on his history and general physical condition.

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Prescribe occupational therapy: Work removes worry.—Fetterman.

One pound of learning requires ten pounds of common sense to apply it.—Persian Proverb.

Medical Management of Arthritis

The patients found most difficult to manage were those who had mechanical, irreparable defects of the joints and those with exceptional emotional instability. In the latter group, it was important to determine whether the emotional instability was, in part, induced by long protracted periods of pain and disability resulting from arthritis inadequately treated, or whether amenable to therapy, were given the necessary treatment or referred to other special clinics with suggestions for management.

An effort was also made to see that each patient received the optimum diet, including adequate amounts of all the essential vitamins and minerals. High-caloric diets were prescribed for those patients who were under normal weight. Low-caloric diets and other methods of weight reduction were prescribed for those arthritic patients who were overweight, particularly when the weight-bearing joints were involved. Two of the patients in our series had cholecystitis. There is a possible relation between the chronic cholecystitis and the patient's arthritis, since cholecystitis is an infectious process.

In any discussion of arthritis, gold therapy must be mentioned. A few of our patients received weekly myochrysine injections. No untoward reactions were observed. However, in general, it is agreed that gold therapy is more advisable in cases of pure rheumatoid arthritis than in any other form. Approximately 48 per cent showed some improvement. All authors agree as to the dangers of toxic reactions.

All of the patients who had had arthritis for two years or longer, prior to their entrance to the clinic, were given heat-vaporized electrically-activated ergosterol.

In most cases three capsules of vitamin D (Whittier process), containing 50,000 U.S.P. units, were given, one after each meal. The dose was then gradually increased until six capsules per day were given. A procedure, found to be very satisfactory, is as follows:

1st three days—3 capsules, one after each meal.

4th to 6th day—4 capsules, one after each meal and one at bedtime.

7th to 9th day—5 capsules, one after each meal and two at bedtime.

Thereafter: six capsules daily (300,000 units).

After improvement had been noted for some time, the dose was gradually decreased. Earlier cases of arthritis responded rapidly but the cases of long duration often responded much more slowly. In some, beneficial results were obtained in from three to six weeks, while in others there was no demonstrable effect until after three months.—Daniel H. Levinthal, M.D., Catharine E. Logan, M.D., Kate H. Kohn, M.D., and William I. Fishbein, M.D., Chicago; Industrial Medicine, Vol. 13, No. 5, May, 1944.

Ruptured Dissecting Aneurysm Associated With Syphilitic Aortitis*

JOSEPH C. SHERRICK, M.D.

Case History. A colored male, 57 years old, had three admissions to University Hospitals. The first was in January, 1942, for excision of a non-toxic thyroid adenoma. At this time, his blood pressure was 160/110. X-ray studies showed cardiac enlargement and diffuse dilatation of the arch of the aorta. Blood Kline and Wassermann tests were negative, and a lumbar puncture showed no abnormality. History revealed, however, that he had had a small penile sore in 1905, had been told in 1932 that he had syphilis, and had received one hip injection at this time.

After discharge, he was fairly well until April, 1943, when he began to have dyspnea on exertion, orthopnea and edema of the ankles. The second hospital admission was in October, 1943, for these complaints. At this time his blood pressure was 194/140, and signs and symptoms of cardiac failure were present. The heart was markedly enlarged to the left, and harsh systolic and diastolic murmurs were present at the mitral and aortic areas. The patient was digitalized and treated with potassium iodide and bismuth. The symptoms of cardiac failure were relieved and he was discharged.

The last hospital admission was on December 12, 1943, for sharp pain, of great intensity and sudden onset, in the mid-thoracic region posteriorly, radiating to the upper abdomen. The temperature was 38.2° C., pulse 86, respirations 28, blood pressure 210/120. The patient was a well developed, slightly obese middle-aged negro appearing acutely ill and complaining of intense pain in the back. Moist rales were heard in the lower portions of both lungs. The heart was enlarged to the left anterior axillary line, and mediastinal dullness was increased in width. Systolic and diastolic murmurs were again heard at apex and base of the heart. The abdomen and extremities were normal and all peripheral pulses were readily palpable and equal. Laboratory examination revealed: Urine — specific gravity 1.023, albumin 3 plus, sediment normal; blood—normal cell counts, negative Kline exclusion test, and blood urea nitrogen 13.5 mg. per 100 cc.; X-ray of chest showed an increase in the size of the heart and the transverse diameter of the aorta as compared with the previous examination three months before. Dissection of the previously described aneurysm was suggested. An electro-cardiogram showed abnormal left axis deviation and myocardial damage. The patient was treated with morphine and digitalis but his pain persisted. On his third hospital day he died, ten minutes after sudden onset of marked tearing pain in the chest.

Autopsy. Autopsy revealed a dissecting aneurysm involving the aorta, common and external iliac arteries, bilaterally. This had ruptured into the left pleural cavity and produced a hemothorax of 3500 cc. The intimal tear, through which the lumen of the aorta and the lumen of the dissection communicated, was in the lower portion of the thoracic aorta, parallel to the long axis. There was active syphilitic aortitis with a cylindrical aneurysm of the ascending portion, arch, and upper thoracic part of the aorta. There was slight idiopathic medial necrosis of the aorta. The heart weighed 680 grams and showed marked hypertrophy and dilatation, especially of the left ventricle. There was no deforming valvular disease. Other diagnoses included atelectasis of the lungs, marked on the left, acute hyperplasia of the spleen, arterial and arteriolar nephrosclerosis, and passive hyperemia of the viscera.

DISCUSSION

Although dissecting aneurysm of the aorta has been recognized anatomically since it was first described by Morgagni[1] in 1761, the clinical diagnosis is difficult and has only recently been made with reasonable certainty. In 1940, Rogers[2] could find only 33 published cases in which the condition was recognized before death. However, the clinical syndrome, when well defined, is so characteristic that the diagnosis if made is usually confirmed at autopsy. The clinical syndrome is well summarized by Neihaus and Wright.[3] Coronary thrombosis is the main condition to be differentiated. The proper diagnosis is suggested by the sudden onset of severe tearing interscapular pain radiating up and down the back, to the neck, the thighs or the upper part of the abdomen, alteration of peripheral pulses, presence of hypertension, roentgenologic evidence of rapid increase in aortic size, normal electrocardiogram and bizarre neurological signs depending on the location of circulatory interference due to the dissection.

In this case the character of the pain, the hypertension, the increase in aortic size and failure of electrocardiogram to show myocardial infarction, led to the diagnosis of dissecting aneurysm. Syphilitic aneurysm was considered because of the history of syphilis and the previous roentgenogram. It was thought that both conditions might be present.

Anatomically the case was unusual because of the location and direction of the intimal tear, the absence of extensive cystic medial necrosis of the aorta, and the associated syphilitic aortitis. The site of predilection for the intimal tear is a

*This is the twentieth of a series of "Case Records Presenting Clinical Problems, selected by H. T. Karsner, M. D., from the Clinical Pathological Conferences of the Institute of Pathology, Western Reserve University and University Hospitals, Cleveland, Ohio.

short distance above the aortic valve, and the tears are usually transverse or oblique.[4] In this case the longitudinal tear in the thoracic aorta was presumably due to local weakness of the wall at this point.

Dissecting aneurysm probably never occurs in a normal aorta; some sort of damage to the medial coat is necessary.[4] In this case a few tiny areas of medial necrosis were present, but were no more marked than is usual in the aortas of patients of this age. However, intimal arteriosclerosis and active syphilitic mesaortitis were present. The role of syphilis in the causation of dissecting aneurysm has been disputed. The two diseases co-exist rather infrequently; syphilitic aortic aneurysm was presented in 4 of 26 cases of dissecting aneurysm autopsied at the Institute of Pathology of Western Reserve University and University Hospitals.

It is interesting that in this case, as in the three reported by Lifvendahl[5], the syphilitic mesaortitis was most marked at the site of the intimal tear. However, others, including Klotz and Simpson,[6] believe that the medial fibrosis of aortic syphilis should render the vessel wall less susceptible to dissection. In the case reported it is noteworthy that the dissection, although it extended inferiorly into both common and both external iliac arteries, stopped superiorly at the aortic arch, where the gross changes of syphilis were most marked. Cabot Case 27302[7] showed similar apparent arrest of dissection by syphilitic medial fibrosis.

SUMMARY

This case is reported because of several features. 1. The combination of cylindrical syphilitic aneurysm and dissecting aneurysm of the aorta is infrequent. 2. The diagnosis of this combination together with rupture of the aorta was made in this case in life. 3. The degree of medial necrosis was slight in comparison with that usually observed in dissecting aneurysm. Of additional interest is the apparent limitation of the dissection by syphilitic medial disease.

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The Clinical Significance of Bleeding in the First Half of Pregnancy

Ectopic pregnancy may present a characteristic clinical picture or it may simulate pelvic inflammatory disease or early uterine pregnancy. It is with the last type of case that we are chiefly concerned in this discussion. One should never be too critical of the colleague who mistakes an ectopic pregnancy for an early uterine gestation. Such patients frequently report the onset of slight bleeding after several weeks of amenorrhea. On bimanual examination at this time, the tubal mass produced by the growing ovum may be so small as to escape detection. Advanced destructive changes in the tube and intraperitoneal hemorrhage have not occurred as yet so that tenderness is absent. Sufficient uterine enlargement and softening may occur due to the development of the decidua and to loss of uterine tone so that the characeristics of early uterine pregnancy are closely imitated. The initial diagnosis in such cases is often that of early uterine pregnancy with threatened abortion. Such a picture may change rapidly so that within a few hours or days it is equally characteristic of extrauterine gestation. Some warning may take place in the appearance of unilateral cramp-like or knife-like pain, or the change may be ushered in by violent pain accompanied by a period of temporary syncope and the appearance of abdominal tenderness usually most marked over one side of the lower abdomen. Bimanual examination of such a patient will almost always yield definite evidence of an extrauterine pregnancy in the presence of a unilateral, exquisitely tender, indefinite mass and in marked sensitivity to the motion of the uterus. If clinical evidence of intraperitoneal hemorrhage is present as indicted by a rapid pulse, a fall in blood pressure, and abdominal distention, immediate laparotomy is indicated. When evidence of internal hermorrhage is absent, particularly if any doubt exists as to the diagnosis, the patient may be put at complete rest under observation. It should be emphasized that such observation should always take place in a hospital because of the danger of a sudden internal hemorrhage which may necessitate immediate surgical intervention.

Hydatidiform mole, a rare disease of the ovum occuring about once in every 1,500 pregnancies, is almost always accompanied by uterine bleeding. The sanguineous discharge usually begins after a short period of amenorrhea and persists for varying lengths of time. The untreated case usually terminates by spontaneous abortion between the second and fourth month. In such cases, the source of bleeding is most likely from lesions of the decidua capsularis which is subjected in many instances to overdistention by the rapid growth of the mole.—William F. Studdiford, Jr., M.D., New York; Connecticut State Medical Journal, Vol. VIII. No. 5, May, 1944.

The Recognition of Non-Pollen Allergy of the Respiratory Tract by the General Practitioner

RAYMOND S. ROSEDALE, M.D., M.Sc., (Med.)

ALTHOUGH the field of general allergy has been fairly well established in the last three decades and although much time, many publications and considerable attention in other forms has been given to the subject of respiratory tract allergy, one still meets many times, practitioners who apparently are unaware of the frequency of respiratory tract allergy, its manifestations, progress, complications and treatment. It is for this reason that this article, which is not intended to present the findings of any original research, nor to enter into any of the contentious questions in this field, is being written. It is intended as a simple review of some of the problems in respiratory tract allergy that are seen in every day practice by the otolaryngologist, who does his own clinical allergy investigations.

The Author

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DEFINITION

The patient with respiratory tract allergy not infrequently admits a family history of asthma, hay fever, hives, migraine, eczema, cyclic vomiting, catarrh, bronchitis or some other allergic manifestation. Allergy is an inherited constitutional weakness. It tends to follow the Mendelian law and usually a positive family history can be obtained. One is sometimes asked the question "if this is so why are the allergic symptoms not always present at birth?" It is believed that the inherent allergy characteristic may be a dominant or a recessive one. If dominant, and a definite exposure to sufficient allergens is made shortly after birth, such allergic conditions as eczema or asthma may be seen in early infancy. If recessive, symptoms may not become manifest until later when the individual meets an unusual amount of the offending allergens, or has an encounter with multiple offending allergens each of lesser degree, or through disease, physiological stress, psychic or physical trauma is weakened and the allergy reactions become manifest.

Frequent colds are complained of by the patient with nasal allergy, or a "cold all the time." Many investigators believe that ordinarily the average individual has only two to three colds a year. When one has them more frequently one should think of the possibility of nasal allergy, suppurative nasal sinusitis, or some other disease, such as a foreign body in the nasal cavities, etc.

OBSTRUCTION

Nasal obstruction is a common complaint. This may be shifting in character. It is usually intermittent unless as sometimes happens, nasal polyps, develop to an occlusive degree. The obstruction may be initiated by changes in temperature, air currents, the placing of the bare feet on the cold floor, etc. As in vasomotor rhinitis these are trigger influences which are not an integral part of the disease. Nasal obstructions on awaking are common in those who are allergic to such inhalants as cotton linters from bedding or feather particles from pillows. House dust may also be an offender of this type.

SNEEZING

Sneezing likewise is a common complaint of the patient with nasal allergy. The normal individual sneezes seldom. The allergic patient may sneeze three to twenty or more times on occasions. In those who are sensitive to orris root this may follow the use of cosmetics, or shaving soap. Sometimes it is due to the application of material used in "setting" the hair. Karaya gum is a not uncommon offending substance in this regard. Sneezing after eating is almost pathognomonic of food allergy. There are instances where the inhalation of the odor of raw bacon or the fumes of frying pork will cause violent sneezing in the case of individuals sensitive to pork.

Akin to sneezing and nasal obstruction are the symptoms of itching and a burning sensation of the nose and eyes. These most often reach their greatest degree in hay fever. However, the former especially, are quite common in food and dust allergy. The itching of the nose may be so annoying to the adult patient that he acquires the habit of picking at the nose and rubbing it even though one fails to

Since the proof of this article was corrected, a paper entitled "Allergic Bronchitis" by J. W. Thomas, M.D., and Ross V. Taylor, M.D., was published in the Annals of Allergy, Vol. 1, No. 3, Nov.-Dec., page 185, which is a valuable paper for every practitioner to read.

find any crusting therein. Rubbing of the nose is commonly seen in children who have nasal allergy. This is not a common symptom in children with chronic purulent sinusitis. One of the commonest symptoms of nasal and paranasal sinus allergy is nasal and postnasal discharge. This is the principal complaint of some patients. They state that they have a sense of fullness in the region of the nasopharynx and that they feel obliged to hawk down and expectorate the offending material. Prolonged and violent efforts sometimes lead to the expectoration of mucoid material. Sometimes the expulsive efforts are so violent, because of the tenacious nature of the secretion that vomiting ensues. In other individuals relief will be experienced after eating or drinking, presumably because the swallowing movements lead to the descent of material adherent to the posterior aspect of the upper part of the uvula and soft palate.

HEADACHE

Headache is the principal complaint of some patients who have nasal allergy. This is most commonly described as dull and compressive in character, frequently intraorbital in location, sometimes frontal but may be biparietal or occipital. In acute allergic occlusions of a maxillary sinus proved by suitable objective studies, I have seen pain of such severe degree that it was not appreciably diminished by the administration of morphine. Fortunately this degree and type of pain is uncommon. The headache frequently comes on in the midmorning or may be present on waking. Sometimes there is an accompanying sense of mental dullness and lack of interest in the usual activities of the individual. One of the minor nasal complaints of some patients with nasal allergy is loss of the sense of smell.

A history of aggravation of nasal complaints following a simple nasal operation is far from being unknown in patients with nasal and paranasal sinus allergy. Such a history in itself should suggest the possibility of allergy. Allergic symptoms referable to the throat are seen in some patients. These are a sense of swelling, or ill defined irritation. The one most often encountered is a sense of scratchiness and itching. Many times such patients have had their tonsils removed without relief of the symptoms, or, exaggeration of them. Sometimes there is dysphagia of short duration.

SWELLING OF LIPS

The mouth and lip symptoms of allergic origin are fairly well defined. Swelling of the lips, vesicle formation, crusting, herpetic lesions, and so-called canker sores of the lips and the mouth are seen. A technician in my own laboratory developed large vesicles on the lips and in the mouth every time she ate brazil nuts. Throughout the literature similar cases are described. Not so frequently described, however, are the patients who have a sense of scratchiness and swelling in the throat after eating certain foods, or engaging in occupations with a new dust environment. These patients are without fever or constitutional symptoms of febrile origin. In two such cases which I biopsied with a fine punch there was a fine eosinophilic infiltration.

Laryngeal symptoms of allergic origin may vary all the way from mild hoarseness to complete laryngeal obstruction requiring tracheotomy. It is a common observation that the patient with nasal and paranasal sinus allergy is hoarse, especially at times. There are some patients who run the whole gamut of the above symptoms on eating certain foods, viz., nasal obstruction, sneezing, itching, and a burning sensation of the nose, nasal and postnasal discharge, headache, itching and a burning sensation of the throat with a sense of swelling, hoarseness, and in rare instances dyspnoea. However, the majority of patients do not have this whole train of symptoms.

The eustachian tube shares in allergic upsets of the nasopharynx in some individuals. Since it is an out-pouching, as it were, of the upper air passages, it can properly be considered here. In individuals with eustachian tube obstruction of allergic origin the symptoms are the same as in obstruction due to simple catarrh. These are, namely, a feeling of fullness in the ear on the involved side, diminution of hearing, sometimes tinnitus, and occasionally sharp twinges of pain. There is sometimes a clicking sensation. A characteristic symptom is the variation in the conduction hearing threshold. Sometimes there is dizziness which apparently is due to the in-driving of the stapes with the retraction of the ear drum.

ASTHMA

Finally, we come to the vexatious subject of asthma. True bronchial asthma is due to anatomico-physiological changes in the bronchi, termed broncho-spasm. Excluding such localized causes as bronchial ulceration, tracheo-bronchial foreign bodies, benign and malignant tumors of the bronchi, etc., it may be considered that bronchospasm is of allergic origin. Therefore, after suitable steps, such as the recording of the history, the physical examination, the taking of chest X-rays, lipiodol bronchograms and bronchoscopy (the latter in certain cases) and no other pathology demonstrated, one can only go ahead with the allergic investigation. Too many times one hears of the futility of the allergic investigation of the asthmatic, but never from those who are trained in such investigations. Symptomatic treatment should not be allowed to exclude

the basic investigation of this disease. The symptoms and signs of asthma are too well known to be described here. However, one might add that trite aphorism "all is not asthma that wheezes."

Allergic bronchitis is a term used to designate those individuals who have periods of coughing without fever or febrile toxic symptoms, the cough being relieved by appropriate allergic investigation and treatment. This group of cases is probably more common than is generally suspected. Children are not infrequently affected. The cough is unproductive, or only slightly so, of mucous or mucoid material in which eosinophiles may be demonstrated. There is as before stated, usually a family history of allergy and not infrequently a history of upper respiratory tract allergy. Usually the ordinary cough mixtures have failed to stop the cough. In this form of respiratory tract allergy as in all others mentioned above, there may be a history of allergic upsets in other body systems, the skin, gastrointestinal tract, urinary tract, etc.

Having described some of the symptoms of patients with respiratory tract allergy some of the objective findings will be considered. These are relatively simple if one keeps the pathology of allergy in mind. In the allergic response of tissue, there is dilatation of the blood vessels and exudation of plasma with a selective flooding of eosinophiles. This exudation is seen in biopsies of the nose, bronchial tree, throat, and other tissues involved by allergy. With prolonged or repeated allergic reactions the tunica propria of the overlying epithelium may become thickened. In the case of columnar ciliated epithelium there may be a change in their activity. Repeated allergic responses with intervening inflammatory reactions may lead to productive inflammation. The commonest objective finding in the nose of the allergic patient, is a pale boggy swelling of the mucous membrane. This sometimes has a violaceous hue. In many of the early cases, this swollen mucous membrane can be shrunk with vasospastic drugs. This is prevented by productive inflammation in cases of long standing.

POLYPI

Nasal polyps are practicaly always an indication of nasal allergy. They represent edematous portions of the mucous membrane which descend because of their weight. The traction and the interstitial edema compressing the veins and lymphatics further aggravates the edema and thus a vicious cycle is established. This cycle is aggravated by repeated allergic responses. In some patients, for reasons which are not clear, one finds a rather fiery red nasal mucous membrane. In the middle meatus and over the turbinates there may be much mucous.

The pharyngeal mucosa in allergic patients may be strikingly pale and somewhat boggy in appearance. In other instances it is red. Frequently there is accentuation of the lymphoid follicles on the posterior wall. Also one frequently sees hypertrophy of the lateral bands of lymphoid tissue in children. In regard to the larynx one may find some pale bogginess and pale swelling of the false cords. However, most frequently there is no gross pathology visible in the larynx.

The nasal discharges or nasal secretions in nasal and paranasal sinus allergy are usually mucoid. Sometimes they are watery, however. If mucoid, they may be in the form of strings, blobs, or shreds. One cannot be sure that one is dealing with nasal allergy from the gross examination alone. Sometimes even what is interpreted as yellow pus may, in microscopic examination be loaded with eosinophiles. Microscopic examination of the discharges of the respiratory tract should always beundertaken. If a preponderance of eosinophiles is found it may unequivocably be concluded that one is dealing primarily with an allergic condition.

The technique of examining the mucous is very simple. Some is secured with a loop or pipette and placed on a glass slide, dried thereon and gently flamed. It is then treated with either Wright's stain or Giemsa's stain. During colds and attacks of purulent sinusitis the ph. of the nasal secretions and the cytology change. The eosinophiles disappear whilst neutrophiles and later histocytes replace them. In allergic bronchitis the sputum is well known and need not be described here. It should always be remembered that allergy of the respiratory tract predisposes to infection. This is especially true in allergy of the paranasal sinuses, particularly in children. In such cases even the microscopic examination of the discharges may not reflect the basic allergic pathology.

EXAMINATION

There are other diagnostic measures at the disposal of the practitioner to assist in making a diagnosis of respiratory tract allergy. Sometimes there is not an excess of mucous in the nose and there is not the characteristic bogginess of the mucosa at the time of the examination. One may not find any polyps in the nose with ordinary investigation. The nasopharyngoscope in such cases sometimes bring into view small polyps springing from the supero-mesial surface of the middle turbinate. Similarly the use of the postnasal mirror may reveal a typical allergic bogginess with excess of mucous, and polyps in the region of the choanae. In questionable cases where other means of diagnosis of allergy of the respiratory tract have failed, it is permissable to make use of a small cutting punch to remove tissue for histological examination.

X-rays are not of true value in establishing a

positive diagnosis of bronchial allergy. Similarly X-rays are not reliable in establishing the diagnosis of paranasal sinus allergy. In some cases the sinuses are cloudy, in others, they are clear. Thickening of the mucous membrane lining the antra, may be seen in some X-ray films. In the absence of a history of purulent discharge this may be considered as pointing to the possibilities of allergic thickening of this tissue. The instillation of lipiodol either through a trocar cannula under the inferior turbinate into the maxillary sinuses positively estimate the thickness of the mucous membrane. Sometimes the lipiodol outlines polyps in the antrum. Polyps should be considered as definite evidence of nasal allergy. The ethmoid cells can satisfactorily be filled with lipiodol by using the Proetz displacement technique, and the thickness of their mucous membrane determined. This is in cases where the ostia are patent.

COMPLICATIONS

There are certain general considerations too, which will help, in suspecting the presence of respiratory tract allergy when associated with other findings. For example, many patients with allergy have an associated mild hypothyroidism. Then again many patients with respiratory tract allergy have manifestations of other systemic allergy for instance, eczema, hives, or such vasomotor instability as dermographia. Abdominal symptoms such as those associated with pylorospasm and chronic irritable colon are not infrequently found in patients with respiratory tract allergy. Another observation which is not uncommon is that respiratory tract allergy tends to occur most often in people who are of better than average intelligence, who are sometimes emotionally unstable, dynamic, and of a general nervous temperament.

SUMMARY

It may be said that the factors of greatest value in suspecting or making the diagnosis of respiratory tract allergy are (1), a careful positive history and, (2), miscroscopic examination of the secretions. The latter, we believe is necessary to positively establish the diagnosis. If after going through the usual steps, one is not sure that the patient has respiratory tract, allergy, it may be considered proper to give the patient therapeutic tests using such appropriate drugs as ephedrine, neo-synephrin, epinephrine, and propadrine hydrochloride, to see whether or not there is symptomatic relief.

In those patients in which food allergy is suspected, one may use the propeptan diet therapy. Such methods as these viewed in relation to the failure of other forms of treatment of the patient certainly help in the establishment of the diagnosis. However, once the condition is suspected one should always go farther, keeping in mind their limitations, and use such adjuncts as elimination diets, skin tests, (scratch, intradermal or patch tests), passive transfers, luekopenic index, mucosal tests, and conjunctival tests.

If one is constantly aware of the relatively common incidence of respiratory tract allergy and its propensity for the entire respiratory tract, the condition will be more frequently suspected and the diagnosis established by relatively simple procedures. Thereby a number of patients who are so often treated for sinusitis, non specific bronchitis, chronic pharyngitis, chronic coughs of vague origin, headaches, chronic laryngitis, and a whole host of conditions which are masqueraded under a hodge-podge of clinical terms, but which are in reality manifestations of respiratory tract allergy, may be relieved.

Observations on Skin Diseases

The examination and treatment of industrial cases comprise between 25 and 30 per cent of a dermatologist's practice—and the percentage is increasing every month. There are two things that impress one while examining such cases, first, the incidence of skin rashes which could be entirely prevented, and, second, the number of everday, non-industrial dermatoses which workers would like to attribute to their occupation.

It will probably surprise you to learn that, in my experience, the greatest number of unnecessary skin rashes (and incidentally the ones which cause the greatest number of lost days) are those dermatoses that are secondary to the use of the sulfonamide ointments. So common are these that when plant directors and physicians seek advice, their use in the plant is deprecated. The idea that no laceration, skin wound or infection will heal without the use of a sulfonamide ointment or powder has not the least foundation in fact. Yet many firmly believe that the sulfonamides are necessary for the treatment of such conditions. Prior to their introduction into medicine, the skin of workers suffering with lacerations, contusions, and infections healed very nicely following washing the part with soap and water, and the application of a sterile dressing. If the physician or nurse preferred, a dilute non-irritating watery or alcoholic solution of an antiseptic was used under the sterile dressing. Such simple therapy gave excellent results in the majority of cases. Today, the use of one of the newer wetting agents of the alkyl dimethyl benzyl ammonium chloride type can be safely recommended to those treating such cases and can, to advantage, displace the use of the sulfonamides.—George E. Morris, M.D., Boston, Mass.; Industrial Medicine, Vol. 13, No. 5, May, 1944.

The Etiology of Regional Enteritis, the Role of Inflammatory Bands and Ileocecal Valve Incompetence

JOSEPH L. DeCOURCY, M.D.

SINCE 1932, when Crohn and his associates[1] first recognized regional ileitis as a clinical entity, the literature has become replete with reports of cases from all sections of the globe showing that it is by no means a rare occurrence nor restricted to any certain area.

The description of the clinical course, symptomatology and pathology of the disease has been remarkably consistent with the original classification. Much has been learned, however, concerning the site of the lesions. The etiology is still obscure.

Crohn and his associates originally stated that in all the cases which came under their observation there was involvement of the terminal ileum. They found that the lesions stopped abruptly at the ileocecal valve and recognized this as one of the specific features of the condition.

The following year two cases in which the identical process extended to the jejunum were reported by Harris, Bell and Brunn.[2] Brown, Bergen and Weber[3] shortly afterward published their findings in a series of cases in which lesions in the jejunum, ileocecal coil and portions of the colon were indistinguishable pathologically from those found in the ileum. The distribution of the lesions in these cases was as follows: 9 in the ileum only; 3 in the jejunum only; 1 in the terminal ileum and a very small portion of the cecum; 5 in the terminal ileum, cecum and part of the ascending colon.

Because of the generalized character of the lesions, these physicians coined the term "regional enteritis" as more descriptive of the condition. Today it is generally accepted as the nomenclature denoting a non-specific inflammatory lesion with a common clinical and pathological history, involving for the most part the terminal ileum but to some extent any part of the intestinal tract.

That this condition can be acute has been established, although the chronic form occurs with much more frequence. The acute phase is characterized by cramp-like pain, some fever, leucocytosis and tenderness and rigidity localized to the right lower quadrant. The condition simulates acute appendicitis and very frequently surgery is employed. For example, in a group of 17 cases of regional enteritis reported by Koster and his associates,[4] 13 were diagnosed as appendicitis.

Indeed, it was just such a case that has prompted me to present this paper. Upon discovering a regional enteritis at the operating table in a patient who had been diagnosed preoperatively as "acute surgical abdomen", the findings suggested to me a possible cause of the condition. With this I shall deal in greater detail a little further on.

The Author

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In the acute form, the involved areas of the intestinal tract are thickened, soggy and edematous. The serosa has a blotchy red appearance. The mesentery is greatly thickened and contains hyperplastic glands. There may be an accompanying accumulation of intra-abdominal fluid. As resection at this stage is contraindicated, the changes within the intestine are unknown.

Chronic regional enteritis is characterized by a prolonged history over a period of months or years. The complaints are diarrhea, abdominal pain, loss of weight, anemia, fistula formation and symptoms of intestinal obstruction. Bowel movements are usually accompanied by generalized abdominal cramps.

A tender mass about the size of a small orange is usually palpable in the right lower quadrant, often in the region of the appendix or cecum but sometimes in the midline above the bladder or even in the sigmoid area.

On exposure, the normal intestinal folds are distorted by the ulcerative process and edema. The wall of the bowel is tremendously thickened, frequently reaching two or three times its normal density. The lumen is generally contracted and at times almost occluded. The intestine proximal to the involved segment frequently becomes greatly dilated. As the disease progresses, the exudative reaction is replaced by a fibrostenotic process. There is a tendency to perforation or fistula formation.

Histologically, the lesion reveals ulceration of varying extent and depth with thickening of walls and stenosis due to fibrosis. The walls are

infiltrated with lymphocytes, plasma cells and eosinophiles. Giant cells may be present.

Obstruction has been found to be an initial symptom, particularly in those cases in which the onset is acute. In these instances the pathological changes in the small intestine are usually extensive and reach high up into the upper ileum. There is diffuse inflammatory change in the intestinal wall and considerable edema.

ETIOLOGY

The disease has been reported in an 8 year old and in a 71 year old patient. The vast majority of cases, however, range between 20 and 30 years of age. There is a slight predominance in males.

Theories concerning its causes have been advanced, but no definite factor has proved convincing. Tuberculosis has been excluded. Repeated inoculations of intestinal materials in animals have failed to produce any evidence of the disease. No bacterial, virus, biological or chemical agent can be associated with this condition in an etiologic relationship. Some observers have felt that a long-standing chronic appendicitis might prove a factor, but simple removal of the appendix has not affected the condition. Many times regional enteritis has occurred in patients whose appendix had been removed at a previous date.

Bell[5] in 1934 reported that he was unable to produce a lesion of this type in animals by interference with the blood supply and so concluded that it was not a disease of inadequate blood supply. He offered a suggestion that infection in the mucosa spreading to the intestinal wall with edema of the mesentery from inadequate lymphatic drainage or infection in the lymphatics as a lymphangitis and extending to the wall of the bowel, might be a factor in the production of the disease.

A possible explanation of the mechanism responsible for the condition was expressed by Bockus and Lee[6] in 1935. They suggested the possibility of lymphangitis and surrounding inflammation that might encroach upon or infect the blood supply, thus producing a slow devitalization of the involved segment.

Felsen[7] offered evidence that these lesions were the chronic stages of acute bacillary dysentery. Work of other investigators, however, has not borne out this theory. Reichert and Mathes[8] were able to produce a lesion in the bowel which simulated the acute edematous lesion by injecting bismuth into the lymphatics. The occasional recurrence of the disease process at higher levels of the ileum and jejunum after previous resection of the terminal segments about the ileocecal angle would contradict a purely lymphatic block as a causative factor.

Before proceeding with my view on the etiology of regional enteritis, I should like to present the findings in a case in which I recently performed an operation at the Good Samaritan Hospital. The observations in this case have led me to formulate the concepts that I shall discuss shortly.

Case Report. Young female, 24 years of age, complained of epigastric pain of a colicky nature, which had come on suddenly two days before admission to the hospital. The pain was of an intermittent character, occurring about every half hour and lasting from ten to fifteen minutes. On the following day the pain became constant and diffused over the entire right abdomen. She began to vomit on the second day.

Physical examination revealed a well developed female, acutely ill. Temperature was 99,[6] pulse 120, respiration 18. There was rigidity of the abdomen extending from the right iliac crest to the right costal margin. Tenderness was most marked in the right upper quadrant. The left abdomen was flaccid. Hymen was unruptured. Blood count showed 20,000 leucocytes of which 92 per cent were polymorphonuclears. Urine was negative chemically and miscroscopically. X-ray plate of the abdomen showed no abnormality.

Diagnosis based upon these findings was acute surgical abdomen due to either ruptured appendix (retrocecal) or acute cholecystitis. Intravenous administration of 1500 cc. 5 per cent glucose in saline was given and operation performed.

Operation: Long right rectus incision was made. Appendix was slightly congested but not sufficiently to account for the symptoms and the blood count. Further exploration revealed an inflamed bowel in the ascending colon proximal to the hepatic flexure. The area involved measured approximately three inches. The serosa was red and covered with lymph. The cecum and ascending colon proximal to this lesion contained numerous hard fecal concretions. This is an unusual finding in that portion of the bowel. No barium had been given. Gallbladder had normal appearance. At the hepatic flexure, there were several inflamed bands extending from the underlying surface of the liver and the gallbladder and stretching around the hepatic flexure and causing a partial constriction at this point. A diagnosis of regional enteritis, first stage, was made. The bands were divided and 10 mg. sulfanilamide sprinkled over the bowel. The appendix was removed. Wound was closed without drainage.

Convalescence was uninterrupted. There was no postoperative distension. Bowels moved well on the fourth day with an enema. Temperature and blood count were normal on the sixth day postoperatively.

DISCUSSION

The feature that impressed me in this case and led me to the conclusion that it could well be an etiological factor in the production of regional enteritis was the element of obstruction. The inflammatory bands produced partial constriction of the lumen with resultant lymph stasis and hyperemia. Partial obstruction due to constriction of the lumen has invariably been found on operation in regional enteritis. Up to the present time it has been considered a result of the inflammatory process. Cause and effect in medicine, as in the other arts and

sciences, have often been inverted. Perhaps inflammatory bands of connective tissue or an incompetent ileocecal valve cause partial constriction of the lumen with lymph stasis and hyperemia.

As in appendicitis, where for many years the etiological factor could not be established, there were various opinions on the subject, until Wangensteen and Bowers[9] in 1937 were able to reproduce the condition in dogs. The result of their experiments proved that there are two factors in the production of inflammation of the cecal appendage; first, obstruction and second, infection. In the dog, obstruction of the washed appendage produced no inflammation nor did induced infection without obstruction. Obstruction of the unwashed areas, however, always resulted in inflammation. The more complete the obstruction, the greater was the inflammation. It is generally recognized today that the mechanical factor is most important as the causative agent in appendicitis.

As the vermiform appendix is a portion of the bowel, why can not the same phenomena be applied to any part of the intestinal tract? In regional enteritis there is obstruction and presumably infection. Many attempts have been made to reproduce regional enteritis in animals with various bacterial agents but all of these have failed, thus eliminating any single bacterium per se as the cause of the disease No attempts, as far as I know, have yet been made to reproduce the condition by creating obstruction. We are at present conducting such experiments on dogs.

CONCLUSIONS

A case report of regional enteritis is presented, the observations of which have led me to to form a new concept of the etiology of the disease. As partial obstruction is invariably present in this condition, the possibility of obstruction due to inflammatory bands of connective tissue or to an incompetent ileocecal valve as its cause has occurred to me. This would result in constriction of the lumen with lymph stasis and hyperemia. We are now conducting experiments on dogs in an attempt to reproduce the condition.

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Promin, Diasone and Promizole

Promin, Diasone, Promizole and certain related compounds appear to possess in varying degree the ability to restrain development of experimentally induced tuberculosis in guinea pigs. It is recognized that this offers many contrasts with clinical tuberculosis in humans, even though the causative organism is the same.

Clinical and roentgenological data so far made available are as yet inadequate both quantitatively and qualitatively to permit, even tentatively, a positive evaluation of the curative effects of such drugs upon tuberculosis in human beings. Until controlled studies of adequate scope have been reported it is recommended that none of these drugs be used for treating tuberculous patients except under conditions which will add to our knowledge of their clinical action, and in the presence of adequate facilities to protect patients effectively from their potentially serious toxic effects. Patients and physicians must be reminded of the Federal regulations which prohibit distribution of a drug in the experimental phase of development to other than research institutions to which the material is assigned by the manufacturer for either laboratory or clinical investigation.

Any use of chemotherapeutic agents in the treatment of tuberculous patients must, therefore, be regarded as a purely clinical investigation. It must be emphasized that such use is not without hazard and that the roentgenological and clinical evidence reviewed gives no justification at this time for more than a critical interest in the value of these drugs in patients.—Report of Comm. on Therapy, Amer. Trudeau Soc., Amer. Rev. of Tuber., Apr. 1944.—NTA Clip Sheet.

Plan Supplement On Specialists

Announcement is made that the Directory of Medical Specialists is now to be published by the A. N. Marquis Company of Chicago, publishers of "Who's Who In America."

It is planned not to issue the next edition before 1945, on account of the war, but the A. N. Marquis Company will publish a supplemental list of all those who have been certified by the American Boards since the last (1942) edition of the Directory, totaling about 3600. This is to be distributed at cost, and monthly or bimonthly bulletins listing successful candidates for certification at examinations during the additional interim before the next edition, are to be issued as a subscribers' service.

Dr. Paul Titus, Pittsburgh, of the American Board of Obstetrics and Gynecology will continue as the directing editor, and Dr. J. Stewart Rodman, Philadelphia, of the American Board of Surgery continues as Associate Editor.

Communications should be addressed to the Directing Editor, Directory of Medical Specialists, 919 No. Michigan Avenue, Chicago (11), Illinois.

A Case of Acute Leukemia Complicating Pregnancy, With Necropsy Findings in the Fetus*

H. S. APPLEBAUM, M.D.

LEUKEMIA is a rare complication of pregnancy, especially the acute form. Moloney et al.[1] state that only 79 cases so far have been reported in the literature. Wintrobe[2] reports only one case in the acute form. Hence we are presenting one more acute case, with postmortem findings in the fetus. In our case myeloid leukemia had developed in the first half of pregnancy, the course was rapid, and the infant did not survive.

R. B., female, 29, was first referred to me by her obstetrician on March 9, 1943. At that time she was about 3½ months pregnant, and a primipara. She complained of pain in the left abdomen and buttock, of three weeks' duration. Physical examination was entirely negative except for the pregnancy. Liver and spleen were not palpable. There was no adenopathy. X-ray of the lumbar spine and pelvis revealed no pathology. Serology, blood chemistry, and urine were all negative. The blood count showed hemoglobin 71.4 per cent; red blood cells 3,650,000; white blood cells 14,200. Unfortunately no differential count was done at this time. The pain the patient complained of was considered to be associated with her pregnancy, and the patient was put on a regimen of liver, iron, and vitamins, and referred back to her obstetrician.

Three months later, June 10, 1943, the patient was again referred to me, but this time on account of enlarged lymph nodes, cough, anemia, and weakness. Physical examination revealed a definite anemia, moderately enlarged lymph nodes, particularly in neck and axillae, a liver 2 f.b. and a spleen 1½ f.b. below the costal border. Blood count: hemoglobin 50 per cent; red blood cells 2,280,000; white blood cells 114,000; polymorphonuclear leukocytes 52.5 per cent (juvenile 6 per cent, stab 5.5 per cent); eosinophils 1 per cent; basophils .5 per cent; lymphocytes 15.5 per cent; monocytes 6.5 per cent; myelocytes 6.5 per cent; eosinophil myelocytes .5 per cent, and blast cells 17 per cent. Platelets were greatly reduced in number. Evidently we were dealing with a case of myeloid leukemia of great severity, judging by the rapid onset and the relatively high blast cell count. A course of three blood transfusions was given, and prompt improvement in the symptoms and rapid subsidence in the size of the lymph nodes followed. The white blood cells fluctuated between 92,000 and 114,000; the red blood cells rose to 3,820,000, and hemoglobin to 75 per cent.

However, this improvement was short-lived, a matter of about three weeks, and the patient was readmitted to the hospital on July 8, 1943. This time the lymph nodes were markedly enlarged, especially the submaxillary and post-auricular on the right; the cough was very distressing, and weakness had increased. The liver now was about 3 f.b. and the spleen 4 f.b. below the costal borders; the breasts were enlarged and quite firm, of almost a stony hardness—leukemic infiltration"?"—and there was a moderate enemia. White blood cells varied between 87,000 and 150,000; the blast cells now had increased to 32 per cent, and the myelocytes to 11 per cent. X-ray of chest showed enlarged mediastinal lymph nodes, which were the cause of her cough—pressure signs.

Fowler's solution was started prior to her admission, but had to be discontinued on account of gastric disturbances. A course of X-ray treatment above the diaphragms was instituted, together with transfusions. The cough improved some, the lymph nodes literally melted away under irradiation, and even the breasts became appreciably softer.

But the course, in spite of treatment, was rapidly downward. Immediately following the irradiation, the patient developed ulcerative stomatitis, which we had thought might be due to the X-ray therapy, but we soon realized that it was the result of the disease. Patient could take no food by mouth, and nausea and vomiting became persistent. Intravenous glucose, saline together with amino acids were started intravenously; vitamins were given parenterally—all to no avail. The blast cell count on August 2, 1943, rose to 70 per cent. The patient was cyanotic, dyspneic, and complained of weakness.

In desperation we decided to perform a Cesarean operation in the hope of saving the child and perhaps rendering some relief to the patient in terminating the pregnancy. This was done on August 3, 1943. The fetus was found dead and the mother expired several hours later.

Necropsy: By A. M. Young, M.D., and B. R. Cohen, M.D.—Baby boy B. Stillborn.

Anatomical diagnoses: Maceration (moderate), fetus of about 8½ lunar months' pregnancy; atelectasis, all lobes lungs (considerable); aspiration, meconium and vernix caseosa all lobes lungs; subarachnoid hemorrhage (moderate), both cerebral hemispheres; subperiostial hemorrhages, skull; generalized acute passive congestion (considerable); multiple parenchymatous and subserous hemorrhages, especially heart, lungs and liver.

Probable cause of death: Subarachnoid hemorrhage, both cerebral hemispheres, and atelectasis, all lobes lungs in a premature fetus about 8½ lunar months' pregnancy in a case of maternal acute myelogenous leukemia.

Autopsy: The autopsy was performed 4¾

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The Author

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hours after delivery. The pertinent autopsy findings were as follows: male fetus, body weight 1660 grams, body length 44½ cm. The skin showed moderate maceration with sloughing of the upper layers of the epidermis, especially of the lower extremities. The fluid in the pericardial sac was blood-tinged. Gross inspection of the organs revealed parenchymatous and subserous hemorrhages, most marked in the lungs. The lungs were atelectatic and did not float in water. There was a moderate amount of subperiostal hemorrhage present, and the brain showed a moderate amount of subarachnoid hemorrhage, especially over the convexities of the cerebral hemispheres.

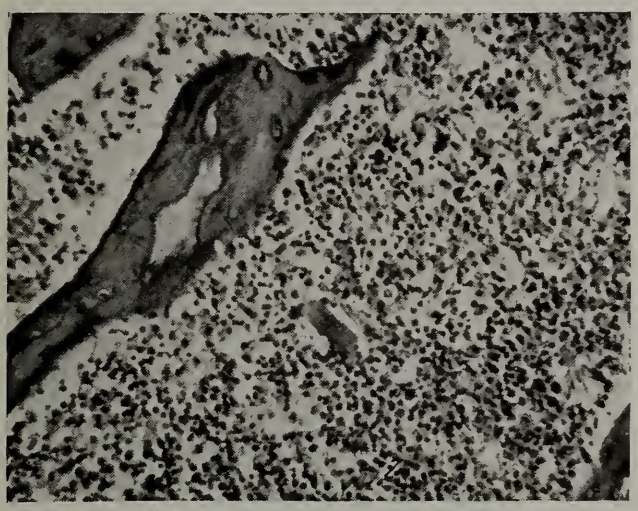


Figure 1. Photomicrograph—Bone Marrow. Normal Bone Marrow.

Microscopic examination of the organs showed moderate autolytic changes. The lungs showed atelectasis and aspiration of meconium and vernix caseosa. There were parenchymatous and subserous hemorrhages in the viscera without regional cellular infiltrations, apparently due to intra-uterine asphyxia. The liver showed small islands of myeloid cells corresponding with the prematurity of the fetus. The bone marrow of the rib was fairly well preserved and showed the average number and distribution of myeloid cells (see Figure 1). There were no leukemic infiltrations of the lymph nodes or spleen or of any of the 23 sections taken from the various organs.

The diagnosis of leukemia implies a fatal outcome. There is no known treatment that can delay the end. Saving the mother was thus out of the question. We had hoped, though, that we might save the fetus, but we failed. However, this was not surprising. The mother was rapidly going downhill clinically, and from the hematological point of view, the rapid increase in the blast cells, from 17 per cent on first examination to 70 per cent the day prior to her exitus, presaged a short course. Death of the infant was evidently due to some cause other than the leukemia, most likely to a rapid intoxication and general exhaustion of the mother.

The interesting features in this case are:

1. The great enlargement of the lymph nodes, particularly the cervicals, which were present on the second examination and which subsided spontaneously after three transfusions, and their reappearance in even greater size on her third and last admission to the hospital. This phenomenon is unusual in myeloid leukemia, but may occur.[2] In contrast to this we recall a case of lymphatic leukemia with a huge spleen and no enlargement of the lymph nodes that we could make out.

2. Patient showed what was probably marked leukemic infiltration of the breasts. These were quite large and very firm, and also responded appreciably to X-ray therapy.

3. The most significant factor in this case, however, is the confirmation of the belief that a leukemic mother probably does not transmit the disease to her offspring, as evidenced by the absence of leukemia in the fetus upon postmortem examination.

The rapid course may or may not have been influenced by the pregnancy. There are differences of opinion on this point. This does not controvert the views of Grier and Richter[3] that a patient who becomes pregnant early in the course of chronic myelogenous leukemia will usually give birth to a living child, and that in four out of five instances she will survive the delivery. Our case definitely falls in the acute stage.

As regards treatment, blood transfusions for anemia and irradiation for the symptomatic relief of pressure signs (due to enlarged lymph nodes) were the only agents of any benefit to our patient. The nodes literally melted away under X-ray therapy—a common experience—and the cough, the result of enlarged mediastinal nodes, proved by X-ray greatly improved. We gave the X-ray treatment above the diaphragms as we were a little apprehensive as to the effect upon the fetus if administered to the spleen. However, many authorities believe that the spleen could be irradiated with impunity, if it were done cautiously. Other supplementary treatment either irritated the patient or proved to be of no value.

We might have saved the fetus by an earlier operation, but we were opposed in that by the family in the belief that an operation would kill the patient—which belief we readily endorsed.

SUMMARY AND CONCLUSION

A rare case of acute myeloid leukemia complicating pregnancy is presented. In addition we are presenting postmortem findings in the fetus in which no evidence of leukemia was found. This is another link in the chain of evidence that "a leukemic mother has never given birth to an infant with leukemia".[3] This then suggests that leukemia in man is probably not transmitted by the mother to the child.

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Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

SMALLPOX VACCINATION AND PULMONARY TUBERCULOSIS

A search of the literature gives little information regarding the possibility of vaccination for smallpox being the causative factor in a subsequent flare-up of latent or active pulmonary tuberculosis. Blacher (1931) has recorded two cases, both in children. In the first of these a boy aged 11, suffering from dystrophia adiposogenitalis, developed a tuberculous meningitis following re-vaccination, and from this Blacher concluded that the vaccination had re-activated a pre-existing tuberculous focus. His second case was that of a girl aged 11, whose skiagram showed a small hard focus in the right upper zone. She was subsequently vaccinated, and ten days later there was fever and X-ray evidence of re-activation of the pulmonary lesion.

Ainger (1937) recorded two further cases where tuberculous meningitis followed immediately on vaccination, and from this he drew the conclusion that either vaccination lowered the powers of resistance, thus paving the way for a fresh infection, or that an inactive lesion already present flared up as a result of the procedure and spread unopposed throughout the lung.

Stone (1931) reported the results following the vaccination of 337 patients at the Robert Koch Hospital, St. Louis. All stages and types of pulmonary tuberculosis were included in Stone's cases, and only one patient showed any definite pulmonary exacerbation, while two others had a temporary increase in the amount of cough and sputum. His view, therefore, was that the presence of pulmonary tuberculosis was not a contra-indication to vaccination.

In the summer of 1942 there was an outbreak of smallpox in Glasgow, and later in the same year in Edinburgh and Fife. Considerable numbers of the public were vaccinated, and one of us (R. Y. K.) received numerous requests from former patients of the sanatorium for advice as to whether, in view of their previous pulmonary infection, they should undergo vaccination. Those living or working in Glasgow were advised without hesitation to be vaccinated, as it was felt that the results of smallpox would be much more disastrous than any post-vaccinal flare-up in the chest. As far as is known, none of those advised suffered any ill-effects. Later in the year four cases were admitted to the sanatorium, all of whom gave a history of vaccination followed almost immediately by the appearance of symptoms of pulmonary tuberculosis.

CASE RECORDS

Male, aged 28. This man, an engineer by profession, had an excellent medical history and for years had not been off work for a single day. In June, 1942, he applied for a post abroad, and before acceptance he underwent and passed a medical examination. A condition of his appointment was that he must be vaccinated in this country before departure, and this vaccination was duly carried out by his own doctor in July. Four days following the vaccination he had a severe reaction; he felt feverish and his arm was swollen and tender. After a further three days he developed a sharp pain in the left chest, which proved to be the beginning of an acute pleurisy with effusion. The subsequent skiagram revealed bilateral infiltration with cavitation in the left upper zone. The patient stated most emphatically that prior to vaccination he had felt perfectly well and had been able to do his work, which entailed considerable physical effort, without the slightest inconvenience.

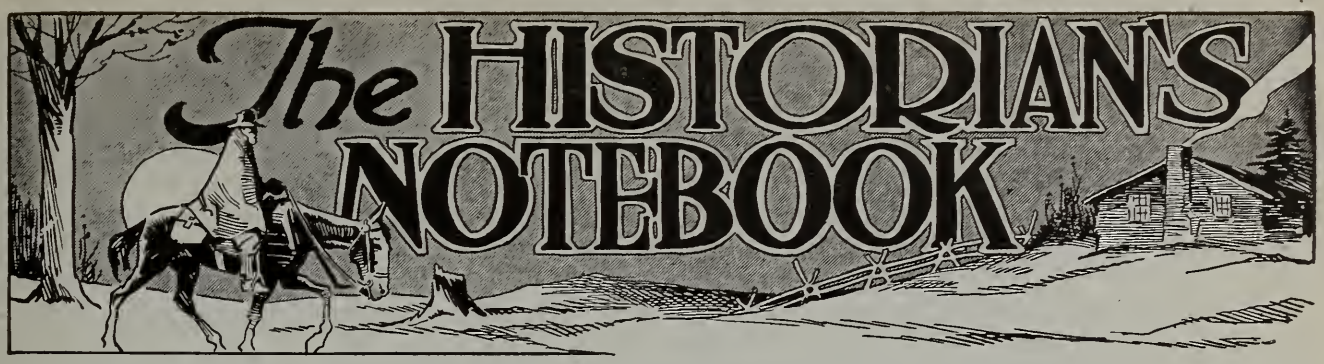
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DISCUSSION AND SUMMARY

In view of the relatively few references to the association between vaccination and pulmonary tuberculosis which we have been able to find it is felt that these cases should be recorded. It is impossible to draw any definite conclusions from isolated instances such as these, but it would appear that there is sufficient evidence here to justify the assumption that vaccination may cause a flare-up in a latent focus.

Our results are at variance with those reported by Stone, but it should be remembered that his cases were under sanatorium conditions at the time of vaccination, while those we have recorded were engaged in their normal occupations, and therefore no more precautions were taken in their cases than would be taken with the average healthy individual.

The necessity for widespread vaccination of the population will not, we hope, arise again, but should it so happen it would be well to exercise special caution before submitting to vaccination known cases of pulmonary tuberculosis.—Smallpox Vaccination of Pulmonary Tuberculosis, R. Y. Keers, M.D. and P. Steen, M.D., British Journal of Tuberculosis and Diseases of the Chest, July-October, 1943.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

Care of The Crippled

EDWARD HARLAN WILSON, M.D.

THE Care of the Crippled needs to be presented in its broadest aspects. My own perspective looks back nearly twenty years when the practical side of the work was in its early stages, more or less feeling its way along, and unsure of which courses would lead it to the open sea without piling up on the reefs that lay ahead. In those days it was difficult to believe that would be able to feel as we do today, that this work is on a sound basis with maturity almost in sight.

The early 20's marked the rise of orthopaedic surgery as an independent specialty. The pioneering word had been done in the last century. McEwan of Edinburgh in mid-century had devised a few successful operations such as the osteotomy for knock knee and tenotomy for wry neck (torticollis) while machines had long been devised to fracture legs for the correction of such deformities as bow legs, and deformities which occurred in the healing of fractures. All of the early open operations had to be carried out through microscopic incisions to minimize the frequently fatal infections which always followed surgery before Pasteur and Lister.

In the last decades of the 19th century some of the profession had devoted a great deal of time to the hitherto neglected tubercular bone and joint disease. The early Children's Hospitals all originated for the care of this then prevalent disease. Lastly, toward the end of the century, Lorenz gave great stimulus to corrective surgery when he adventured in the reduction of congenital dislocation of the hip.

There had been disappointments too. Throughout the middle ages and down to the 17th century attempts had been constantly made in the correction of scoliosis. These efforts were largely confined to the makers of armour. The usual procedure was to take a youthful patient under contract for a term of years into the home of the armourer. A steel corset was then designed and changed from time to time to force further correction. From letters extant one can judge definitely that the method was unsuccessful, extremely painful, and that the patient was in the end reduced to a pitiable state of general health.

The other great failure was the treatment of club foot, by cutting the tendon of Achilles as advocated by Little. For a brief time, apparent improvement resulted but the two main elements of the deformity were uncorrected and the foot ultimately relapsed and became untreatable. Byron was a victim of this method and the result contributed to the bitterness of his character. His special shoes can be seen today in the British Museum.

THE FOUNDATIONS

During these years and up until World War I a few men laid the foundations of orthopaedic surgery in America. Goldthwait, Lovett and

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Read before the Ohio Welfare Conference, Columbus, Ohio, on October 6, 1943.

Osgood of Boston, together with Hibbs and Whitman of New York and Ridlon of Chicago, became the teachers of my generation. We had in Ohio two members of the early group, Dr. A. H. Freiberg and Dr. Stern. Dr. Frieberg was chairman of the advisory Medical Board in the early days of the Ohio Plan and all of us should be eternally in his debt for the wise counsel and balanced perspective that he brought to those trying days.

Nothing has demonstrated so clearly the progress of medicine as the contrast between World War I and our Civil War, in the handling of military casualties. These were the two greatest wars of that period. In the Civil War, military medicine was in the hands of the Sanitary Corps. It was poorly organized and not much was expected of it. The cause of infection had not yet been discovered and surgery was still trapped behind the barrier of infections. Laudable pus was still thought to be nature's healing ointment and, together with high fever and frequent death, the necessary sequale of all operative procedures.

Since the dawn of history, serious open wounds involving the bones, had resulted so inevitably in death that the only known life saving treatment was amputation. During all those centuries there had been only one improvement. Ambrose Parre, the famous barber surgeon of France's Francis the First, had substituted ligature of the vessels for boiling pitch to prevent fatal hemorrhage after amputation.

Keen has left a vivid description of Civil War surgery. He described a hasty trip he made from Washington to Bull Run to serve the wounded in that first Union defeat. Almost two-thirds of his armementarium consisted of spiritous liquors which were the anesthetic, stimulant and sedative in general use. Although ether had been discovered over 20 years, there was none to be obtained in sufficient quantity for the emergency. The seriously wounded soldier passed through his valley of tears with the aid of a shot of whiskey, at the hands of a man in a bloody apron and bloody boots, with hands unwashed. The most prominent furnishings in the operating tent were the large garbage cans in which the severed limbs were deposited, to be carried away to burial. Admiral Robley D. Evans, in his Sailor's Log, described the treatment of his wounded legs which were badly set. Later he had them rebroken and reset.

FIRST WORLD WAR

The First World War found the medical profession still largely uneducated in the prevention of deformities but at least saving limbs. Modern methods of combating tetanus and gas gangrene were first extended to mass use. Modern hospitals with modern nursing were brought up behind the front lines where, because of the static type of trench warfare, civilian type of practice could be carried on. The fact that limbs were saved posed a new problem in military medicine, one which had never before that time been met with. Military medicine called in the orthopaedic profession, so few in numbers that they had to space themselves out in an advisory capacity. At Harvard an eight-week course in orthopeadic surgery for military surgeons was conducted continuously by Dr. Lovett.

Probably the most notable contribution was the reduction of the death rate in compound fractures of the femur from 80 per cent to 20 per cent by the application of traction to all such patients before they were moved. The cause of most of these deaths was shock. The only other effective instrument used against shock was transfusion. Its use was greatly limited by the difficulty in securing matched donors when needed. Toward the end of the war was introduced the first use of blood banks. As whole blood can not be safely preserved over one week, the effectiveness of the weapon was not great. Use of stored dried plasma in this war permits immediate treatment of shock on the field. Shock, we may say, was discovered and observed but not solved during the war.

The other great problem which resulted from the saving of limbs was infection. Medicine put all of its faith in chemical antiseptics in both the prevention and treatment of wound infection. Unequivocally, one may say that faith was completely shattered, although years were to pass before that fact was clearly apparent. Thus we had the development of the Canel Darkin technique in which a wound was bathed by a cold, uncomfortable solution of neutralized chlorine every four hours. The British put their faith in Bismuth Iodoform Paste, the famous Bip.

Following the war came the rainbow age which was initiated by merchurochrome and followed by Gentian Violet, etc., until the entire spectrum had been exhausted. The solution of these problems came gradually and, by one of those strange coincidents of evolution, was ready just in the nick of time to minimize the casualties of this war. I refer, of course, to the use of plasma for shock and sulfanilamide and penicillin for infection.

So in the early 20's when orthopaedic surgery was in the early flush of its young childhood, came a great interest in it on the part of young graduates of medicine. By another of those evolutionary coincidents came a sudden interest in children who were handicapped in the structure of their bodies. Those who formulated the Ohio Plan, which has since spread throughout this country and to even more distant points, were full of infinite wisdom. They had to choose between institutionalism and its accompanying centralization as against regionalization and the preservation of the direct family-to-physician

relationship which has been such a necessary part of medicine.

We must never forget that medicine had its origin in priesthood and that in spite of scientific advances faith still is and ever will be an essential part of cure. It is personal faith which permits parents to place their child in the hands of a surgeon for a not infrequently dangerous procedure and it is faith that permits them to continue that trust when complications occur. An informed parent is a cooperative one. Had a central institution been adopted, the family would not have had that freedom of advice which they now have; suspicion would have entered the picture; there would have been lack of personal contact and grave psychological troubles would have arisen.

In addition, my personal observation has been that no physician develops his best qualities under an institutional regime. Along with this has arisen one problem. The parents tend to seek those surgeons concerning whom they may may have heard the most. Such judgements are not always sound but in the mass are founded on hard work and faithful service. It is in effect an unexpressed law of nature which, if interferred with too much, will disturb the faith of the family. The reward of medicine is a following of patients; it is the innate goal of the physician and keeps up his faith in himself. At the same time, some balance is necessary so that the young surgeon too may have his chance.

THE WORK BEGUN

So the work began. There was no experience to guide it. Wisely it defined the three main factors which should contribute: physical care, education and rehabilitation. One of the early dangers was over dramatization and over elaborated sentimentality which carried the danger of expecting too much from medical care. The fact is that a certain percentage of children can be cured and an almost equal percentage can be helped but little. In between these two groups is the third group, consisting of about 60 per cent of the children who can not be restored to normalcy but who can, by the aid of surgery, either have their disease halted or the degree of crippling materially helped but who, in the end, will present varying degrees of handicapping. For them special facilities for education, accompanied by a certain degree of physical care in the schools has been developed by the State Department of Education. Toward the end of their schooling the Department of Rehabilitation takes over the difficult problem of fitting them for economic independence. The founders of the plan saw very clearly indeed.

The early years found Miss Mabel Smith at the helm of the Division of Crippled Children. One who dealt with Miss Smith through those evolutionary times can properly appraise her contribution. Miss Smith was a graduate nurse and, looking back, one can see that the entire work could have been in peril had there not been one who understood and who was used to working with the profession. She understood our language and we understood her's. Always impersonal with us all, granting no favors, and we asking none, the work grew up in a spirit of mutual trust and esteem. The deciding point for both parties in every problem that arose was unfailingly the welfare of the crippled child and that has persisted in the main to this day. Very few "doctor" vs. administration difficulties ever arose. Under her administration, fees and hospital rates were established and standards of hospital care.

There were many attempts on the part of unqualified men to participate in this work, often with the backing of a local community who failed to understand the implications of their action. A small hospital, struggling in a small community, would arouse public feeling by pointing to the fact that local money was going to an out-of-town hospital when there was a starving hospital at home. Such an action grew out of ignorance, ignorance of the fact that specially trained surgeons and special hospital facilities were required in this work. Miss Smith, with her Professional Advisory Board, stood fast through all of this. Frequent were the political threats to her career. Through it all she stood fast with courage and the serenity of right. When she retired she carried with her the respect and esteem of the orthopaedic surgeons of Ohio for one who had been a splendid public servant.

Her successor, Mrs. Edna Field Cunningham, took up the reins at a time when the work had reached a certain maturity. A totally different set of problems was at hand which carried a great and, we hope, the last threat to the crippled children of Ohio. This consisted of the frequent lack of cooperation on the part of the local county authorities and failure on their part to recognize their financial responsibilities. The most essential foundation of the work is the placing of financial responsibility on the county where it should be. Theirs is the task of deciding how much they can spend each year for this purpose. Frequently they failed to make such appropriation and unpaid debts to the Department accumulated. Nothing could so quickly put a quietus on this work as an accumulated debt—that we can all comprehend as it would put that county outside the possibility of carrying on with new children.

TECHNIQUE FOR FINANCE

This problem came to a head shortly after Mrs. Cunningham took office. The problem was approached by arranging amortization of the debts on a yearly basis and its development in the

future prevented by furnishing each county with an accurate estimate of the cost of each child's care so that the necessary sum could be appropriated before commitment of the child to the Department of Welfare. It has been further minimized by a contribution on the part of the state, and one on the part of the federal government to match that of the county. Most of us feel that it would be a great mistake to take away from the home county its ultimate responsibility.

Thus Mrs. Cunningham has contributed businesslike administration which has allowed the Ohio plan to reach its ultimate maturity. The problems facing its administration at this time are so minor that all concerned feel that the sailing is almost too smooth and that trouble must be brewing. Since its conception over 11,000 children have been furnished care. During the past year 540 new cases were received. The mortality is a fraction over 2 per cent which includes death from all causes including tuberculosis and pyogenic infections as well as operative accidents.

Approximately 3,000 crippled children are handled in special schools per year. Of this number 1,350 attend orthopaedic classes; 650 attend classes in hospitals and convalescent homes; and 1,000 receive home instruction.

Through all these years the administration has been free of political influence. There have been threats to the personnel but fortunately these have failed to materialize. One's faith in the democratic method is strengthened by the experience with the movement. During all the years not one breath or hint of scandal has arisen. Aside from the factors already described there are, I believe, two reasons for this.

One of the most essential factors in contributing to success has been the character and type of field nurses. These women must and have placed the welfare of the children as their main duty. They must be diplomats in handling the county authorities, educators frequently, and capable of rising above the petty irritation which constantly may arise in their dealings with hospitals, physicians and authorities. It is said in England that in normal times Great Britain chooses its premiers for character rather than brilliance. Character must continue to be the basis for selection in the Department of Welfare in order that the same type of devoted public servants we now have may be perpetuated in the future. Some method of temporary appointment should be worked out in order that new incumbents may be observed under field conditions before final confirmation.

The other factor has been the continued interest of the Ohio Society for Crippled Children. Without this interest there have been times when, in spite of everything, political influences might have swamped the Department. Mr. Underwood's organization of county branches of the Society for which there was no precedent to guide him, has been timely. It has furnished the necessary local interest which was greatly needed. Lastly, the Society has performed a great service through its branches by bringing Dr. Phelps of Baltimore into some of the larger communities as consultant on spastic problems. This movement has been of great help both to this unfortunate group of patients and to us who must be responsible for their care.

Some of you might be interested in just how the program works out. Usually the children are found by the county health authorities and brought to a free orthopaedic clinic, the nearest one, of course. These diagnostic examinations are carried out and decision made as to treatment. Report is then made to the county health commissioner and if hospitalization and prolonged after care are necessary application for commitment is made together with an estimate of hospital and medical cost.

At the same time the plan of treatment is discussed with the parents. Once commitment has been made, the child is on the same basis as a private case and the family has full access to the surgeon for advice and common decision. This is as helpful to us as to the family. Through the cooperation of the regional nurses, county nurses and the family, the convalescent period in plaster is usually spent at home. This is, I believe, one of the outstanding accomplishments of team work between all concerned and cuts down the ultimate cost per individual remarkably. The children too are happier to be at home. With good supervision it has proven itself a sound and safe method.

The children are returned to clinic for follow up by the county nurses at designated times. The hospital expense is on a cost basis. The surgical fees average about $75 with a maximum of $100 in a few special complicated procedures. There are many smaller fees. The fee schedule is much as it was set at the beginning and, except for minor revisions largely in the way of simplification, has persisted unchanged through boom time and depression. Some have thought the fees were somewhat generous. As a matter of fact the state is receiving more than a full value. No charge is made for examination of the children during their repeated clinic visits and the important guidance gained therefrom. A great many services are rendered without charge.

PROGRESS MADE

Methods have improved rapidly through the years. I do not believe that any of us are using today any of the procedures that we started with 18 years ago or at least very few of them. Two general classes of patients are encountered; those

who at times of birth are crippled and those who later acquire handicaps.

In general congenital deformities are for the most part curable if taken in time. These include club feet, birth paralysis, congenital dislocation of the hip, wry neck, etc. One evidence of progress is seen in the fact that most of these do now reach the surgeon in time. In earlier days we had to face club feet in children of seven, fourteen, and even seventeen years which had never been under treatment. Sometimes the parents refused treatment in the belief that the deformity was God's mark and should not be disturbed. More refused treatment because of whispered knowledege of bitter failure by earlier methods. Some of these traditions had, I think, been handed down from generation to generation for many years. This has long disappeared after the demonstration of results.

Then, we had our own profession to educate as to what could be done. Not infrequently we had to tell a parent of an eight or ten year old child with a congenital dislocation of the hip that it was too late to reduce the hip and obtain a satisfactory result only to have the reply, "I was advised to wait until this age." Two parts of a hip joint can not grow and form independently for years and then match each other if reduced. The result is always the development of a stiff painful hip. We can now do a compromise operation in these older patients that gives them a fairly satisfactory hip. Tubercular bone disease has become greatly lessened but those wo do see are frequently very serious. Deformities due to rickets are, of course, less.

One of the greatest advances has been in the field of bone infection—the dread osteomyelitis whose victims used to drag their weary way into the hospitals for repeated operations with often discouraging results. The sulfanilamide group of drugs has seemed to abort most of these in the onset stage now. In the chronic cases we are now able to perform a cleaning out operation and then by the use of sulfanilamide close the wound as though it were non-infected and thus bring about primary healing. There are patients who are unaffected by the drug or in whom the location of the disease precludes operation. Reports concerning penicillin hold out hope for these.

On the other hand, there has been a rapid increase in crippling from automobile accidents, burns, etc., while congenital deformities remain at least constant in proportion. At this time they are greatly increased in number coincident with the high birth rate. This, too, applies to spastics, who constitute an unsolved problem, the great group who suffer from congenital apoplexy. It is with this group that Dr. Phelps is helping us. Many of the acquired disabilities will remain constant, such as epiphyseal dislocation, Legg Perthes disease, etc.

SISTER KENNY

Last of all we still have with us and will continue to have with us Infantile Paralysis. How we have dreaded each year the approach of the "Paralysis Season". As a profession we have been through hopeful methods of treatment of paralyzed muscles all culminating two years ago in examination of our results and deep depression over our failure to bring about more recovery. It was clear, we thought, that in the end and in spite of our efforts, the final extent of paralysis depends upon the amount of damage suffered by the motor cells of the spinal cord in the first few days of onset of the disease.

Then came Sister Kenny. She is a rugged, forthright individual, absolutely sincere in her belief in her method, at the same time without any scientific background, who believed that all cases could be "cured". Failure to cure was due to failure to use her method properly in time. To the credit of the profession, we all eagerly grasped for the new weapon and have now had the opportunity to evaluate it in part at least. Sister is one of the finest physiotherapists I have ever met and her knowledge of muscle function is phenomonal. She has had to acknowledge that they do not all get well.

Opinion seems to be crystallizing to the acknowledgement that she has devised a splendid system of physiotherapy, perhaps the best. We hope it will minimize the occurrence of deformity in later life but we are beginning to suspect that the ultimate residual paralysis still depends upon the number of cells destroyed in the cord in the few days of infectious onset and that poliomyelitis will continue to be a major problem until prevention of the disease is at hand.

We do accomplish a lot with crippled children. Very few of them could hope to reach a stage of independence without physical care. The methods of care have improved by leaps and bounds as we have all eagerly sought better methods in the treatment of these children. The safeguard offered tuberculosis of joints by producing fusion of the affected joint results in cure of the disease. The deformities of infantile paralysis can be corrected and wobbly limbs made stable in a much more certain manner than of yore when recurrence brought about repeated operations. By experience we have reduced the number of operations by establishing the proper ages for such operations. Curvature of the spine associated with paralysis can now be permanently improved 60 to 70 per cent by gradual correction and fusion of the spine.

One could make a catalogue of improved procedures and gains in the care of children but such is properly left for professional meetings

and a more critical audience. The point is that, while some can be cured, some can not and that in between are a great number who can be helped. But in main, ultimate independence is attained only by close team work between the home county, physical care under the supervision of the Welfare Department, special education and finally training for life's battles at the hands of the Department of Rehabilitation. Finally, we must secure recognition on the part of employers that we have, all of us together, created a useful individual.

SOCIALIZATION OF MEDICINE

I would call to your attention that this is a special form of socialized medicine. It has been made possible as far as the medical care is concerned by a fairly enlightened profession. Medicine has for the past generation been attracting an exceptional type of young man. It is important to the future of all of our people that those conditions which have permitted the exceptional progress of practical medicine and the attracting to it of good minds be continued.

All of us agree that better medicine must be made available to more people and at a cost they can afford. For the sake of all of you it is important that this come by evolution, not revolution, lest the type of medical care you desire disappear. The result of hospitalization insurance (Blue Cross) offers a hint as to one possible road.

There is before the National Congress the Wagner Bill to socialize medicine by the revolutionary way. I would ask that you consider it carefully. The quality of medicine must be the first thing, not mass production. I saw some some of the latter last year in England. The panel system is satisfactory to neither doctor nor patient but worst of all it has taken that portion of the practice of medicine backward 100 years. There is no disposition on the part of anyone to preserve the system but rather to substitute something better.

The Committee of the British Medical Association on changes in medicine after the war, agree on the need for extension of medicine. They have spoken for the need of avoiding mass production and have said that one of the first requirements of good medicine is the factor of time; time for careful examination, time to think about one's work, and time to study and renew one's education. Most plans for the revolution of medicine ignore these factors and are essentially plans for cut rate treatment on a mass basis. I need only point out to the cooperative medical societies of Holland before the war, the panel system of England and some of the plans already initiated in this country. I am unable to conceive of a revolutionary all-embracing plan which would not reflect itself in poorer health in the community as the ultimate effect and I do not trust anyone who believes that he can.

Rather the road would seem to be the placing of some responsibility on the individual through insurance premiums. Another danger is that medicine might be swamped by the nervously inadequate patient, a great class for whom little can be done by physical methods. And, for your sake as well as ours, preserve that direct relationship between patient and physician which since the dawn of history has been an essential to cure. Never forget that all of us when ill are also mentally sick.

The greatest needs, aside from the middle class who might be cared for through some form of insurance, are the poor and especially the crippled adult who thereby has lost his earning capacity. One reads stories of poor individuals selling their souls in order that young brother might have an operation. There is not a single case of this kind who will not find a physician to care for him.

The usual obstacle is the difficulty of having him hospitalized and followed properly afterwards. That comes back to the community. Take Columbus as an example. University Hospital should be triple its size or some similar institution built to provide adequate beds. The occupants of beds have to eat and be cared for, all of which requires money. The failure in medical care of the poor in most communities lies in failure to provide for such care. Much is to be said for the clinic in connection with a University or other charitable organization. It is by far the cheapest method of care and, best of all, permits the development of young medical men under the watchful supervision of their seniors. The failure to develop such facilities to their fullest state does not lie with the medical profession but with an indifferent public.

The comparative low fees used in the care of crippled children are made possible by the fact that we, each of us, are engaged in private practice and are not solely dependent upon such fees. And remember that no physician gains wealth from his professional efforts nor does he want it. He does have to provide for an old age, which few of us attain, by earnings which are at a maximum for only a few years.

I hope that this diversion concerning the future of medicine has not seemed out of place. The care of crippled children is so intimately a part of general medicine. Failure to continue medicine on its present plane would reflect itself instantly in the quality of care. No thinking physician can possibly oppose the extension of medicine in one form or another but one is concerned that the brilliant record of the past 70 years be preserved for increasing gains in the future.

Official Proceedings of the House of Delegates, Ohio State Medical Association, 98th Annual Meeting, Columbus, May 2 - 4, 1944

MINUTES OF THE FIRST SESSION

THE 98th Annual Meeting of the Ohio State Medical Association was officially opened Tuesday, May 2, 1944, at 3:30 P.M., with a meeting of the House of Delegates in the Red Room, Neil House, Columbus.

President C. C. Sherburne, Columbus, called the meeting to order and then delivered his Presidential Address (See pages 560-2 in this issue). The roll call showed 99 delegates present.

On **motion** by Edward J. McCormick, Lucas County, seconded by Fred W. Dixon, Cuyahoga County and **carried**, the minutes of the meetings of the House of Delegates held on March 30 and 31, 1943, were **approved.**

REFERENCE COMMITTEES

President Sherburne appointed the following Reference Committees:

Resolutions—G. A. Woodhouse, Pleasant Hill, chairman; L. B. Johnston, Cincinnati; F. M. Wiseley, Findlay; F. N. Nagel, Toledo; M. Paul Motto, Cleveland; Wm. M. Skipp, Youngstown; J. W. Calhoon, Uhrichsville; C. P. Swett, Sugar Grove; D. A. Berndt, Portsmouth; Chas. W. Pavey, Columbus; R. P. Bogniard, Ashland.

Annual Reports—Chas. T. Atkinson, Middletown, chairman; J. H. Persinger, Washington C.H.; R. M. Lemmon, Akron; R. D. Dooley, Dayton.

Presidential Address—Robert Conard, Wilmington, chairman; F. M. Hartsook, Cardington; F. W. Shane, Gallipolis; C. A. Marquart, Crestline; D. W. Hogue, Springfield.

Credentials—D. C. Houser, Urbana, chairman; James A. Beer, Columbus; S. J. Podlewski, Steubenville.

Tellers and Judges of Election—D. J. Slosser, Defiance, chairman; C. P. Adkins, Coldwater; J. A. Fraser, East Liverpool.

ANNUAL REPORTS

Annual Reports of officers and committees, which were published in the April, 1944, issue of *The Journal*, were submitted by title and referred to the Reference Committee on Annual Reports.

NOMINATING COMMITTEE

The House of Delegates then elected the following Committee on Nominations with instructions to report back to the House of Delegates at its Second Session on Thursday afternoon:

First District—D. W. Heusinkveld, Cincinnati.
Second District—R. S. Binkley, Dayton.
Third District—E. P. Sparks, New Knoxville.
Fourth District—W. D. Hickey, Leipsic.
Fifth District—J. N. Wychgel, Cleveland.
Sixth District—Wm. M. Skipp, Youngstown.
Seventh District—Carl F. Goll, Hopedale.
Eighth District—A. J. Tronstein, Newark.
Ninth District—D. A. Berndt, Portsmouth.
Tenth District—John M. Thomas, Columbus.
Eleventh District—Ross M. Knoble, Sandusky.

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INTRODUCTION OF RESOLUTIONS

Under the next order of business the following resolutions were introduced and referred, without debate, to the Reference Committee on Resolutions:

Resolution A. Introduced by Robert Conard, Wilmington:

BE IT RESOLVED by the House of Delegates of the Ohio State Medical Association in session in Columbus, Ohio,, May 2, 3 and 4, 1944:

1. That the Board of Trustees of the American Medical Association be commended for having authorized the opening of an office in Washington, D. C., as recommended a year ago by this Association;
2. That the Board of Trustees be urged to maintain at all times an appropriation which will be adequate to provide competent personnel for the Washington office and enable that office to carry on its important activities efficiently and expeditiously;
3. That the Ohio State Medical Association express itself as believing that the American Medical Association is the proper organization to represent the medical profession of this country on legislative matters and questions pertaining to health and medical activities of all departments and agencies

of the Federal Government, as well as similar activities of national unofficial and voluntary groups and organizations;

4. That this Association believes that there is no necessity for the maintenance and formation of independent organizations, composed of physicians and financed by physicians, for the purposes referred to in the foregoing paragraph, for the reason that the American Medical Association has the potential resources, facilities and ability to provide efficient leadership on such matters if the potentialities of the American Medical Association were to be fully developed;

5. That the Ohio State Medical Association pledges its active cooperation to the end that the potential strength of the American Medical Association shall be fully developed and instructs its delegates to the American Medical Association to support proposals which in their opinion would improve and strengthen the American Medical Association so it will be able to fully discharge its responsibilities and meet its obligations during the uncertain period which lies ahead.

Resolution B. Introduced by Louis N. Jentgen, Columbus:

WHEREAS, A special commission authorized by the Ninety-Fifth Ohio General Assembly is making an exhaustive study of the salaries and wages paid to state employes, and

WHEREAS, There is evidence that the salaries paid to many classes of state employes are not commensurate with the work performed and the responsibilities such employes must assume, and

WHEREAS, This situation is especially acute with respect to employes who must possess professional, scientific and technical education and training, notably physicians, attorneys, engineers, nurses, technicians, and those holding important administrative positions, and

WHEREAS, It is becoming increasingly difficult for the state government to acquire the services of a sufficient number of professionally-trained employes for essential positions because of the low-salary schedules of the state as compared to the income which can be derived through private practice or employment elsewhere,

THEREFORE BE IT RESOLVED, That this Association request those elected to the next General Assembly to give serious consideration to recommendations which may be submitted, revising upward the salaries paid by the State of Ohio to physicians and others who must be especially qualified for their duties.

Resolution C. Introduced by Wm. M. Skipp, Youngstown:

WHEREAS, The Council of the Ohio State Medical Association has issued a forceful, sound and intelligent statement in opposition to the enactment of the Wagner-Murray-Dingell compulsory sickness insurance bill, now pending in the Congress, and

WHEREAS, The Council's statement emphasizes that the program proposed by the Wagner Bill would be detrimental, rather than beneficial, to the health and welfare of the American people and that a revolutionary plan of that kind is not necessary to bring about additional improvements in the health of the people of this country,

BE IT RESOLVED by the House of Delegates of the Ohio State Medical Association, in session May 2, 3 and 4, 1944, in Columbus, Ohio:

1. That the statement issued by The Council on the Wagner-Murray-Dingell Bill be officially endorsed and The Council and the Committee on Public Relations be commended for their action in opposing this proposal;

2. That the officers and legislative committeemen, especially, and all members of component medical societies of this Association be urged to actively support The Council, the Committee on Public Relations and the Legislative Committee of the Association in their efforts to disseminate information regarding the Wagner Bill to the people of Ohio;

3. That the medical profession of Ohio through county medical societies take immediate steps to initiate voluntary prepayment medical service plans under the provisions of the Ohio Enabling Act for Medical Service Plans for the purpose of improving the health of the citizens of Ohio, of assisting low-wage earners to budget the costs of medical care, and of making the benefits of modern medical services more readily available to those with limited incomes;

4. That the medical profession, individually and collectively, also encourage and actively support other local and state programs and activities which will promote further progress in the improvement of the health of the people of this state and will result in safe and sane cooperation between private enterprise, the public and the government;

5. That the medical profession of Ohio be urged specifically to cooperate with other interested, dependable groups and agencies in:

Attacking the causes of unemployment and disability;

Encouraging self-protection through thrift, savings and private insurance:

Maintaining a sound, conservative Social Security Program, the efforts of which would be directed toward meeting contingencies which can not be met through private enterprise rather than in placing emphasis upon paying citizens for being unemployed and sick;

Improving social, economic and working conditions generally;

Expanding present programs for improvement of food, housing, recreation and other environmental conditions influencing health;

Expanding present programs of health education;

Improving present local and state programs providing medical and hospital care for the poor;

Improving present programs providing care for and rehabilitation of the handicapped and permanently disabled;

Expanding existing local and state public health programs to meet proven needs;

Emphasizing the importance of financial responsibility on the part of local and state governments—taxpayers generally—in those health activities which are the proper functions of government;

Maintaining a major portion of administrative control in the hands of local officials

and groups to insure a greater degree of efficiency, economy and responsibility;

Accepting the assistance of the Federal Government in an advisory capacity but refusing to yield to Washington bureaucracy on matters which can and should be handled by private enterprise and by local and state governmental agencies;

Expanding hospital facilities when and where needed but assuring administration will be unhampered by political domination;

Increasing the number of beneficiaries of voluntary hospitalization plans.

Resolution D. Introduced by Harry E. LeFever, Columbus:

WHEREAS, the Hon. John W. Bricker will retire as Governor of the State of Ohio at the conclusion of his present term, and

WHEREAS, Governor Bricker during his three terms as Chief Executive of Ohio has taken a leading part in promoting the health and welfare of the citizens of this state by encouraging the formation of sound and beneficial health and medical programs; by appointing qualified and dependable physicians for administrative duties; by seeking the advice and counsel of the medical profession on medical and health questions; and by opposing proposals which would be detrimental to the health and welfare of the people of Ohio,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association, on behalf of the medical profession of this state, officially commend Governor Bricker for his sound attitude on medical and health questions and for his vigorous and outspoken opposition to proposals which would lower health and medical standards, weaken present health laws and administrative procedures, and destroy the private practice of medicine.

BE IT FURTHER RESOLVED, That this Association express to Governor Bricker sincere appreciation for the numerous opportunities he has given representatives of the medical profession to confer and counsel with him on questions in which the physicians of Ohio are deeply interested and which have been of vital interest to the health of the citizens of our state.

Resolution E. Introduced by F. N. Nagel, Toledo:

WHEREAS, The National Physicians' Committee for the extension of medical service has thoroughly proved its value to the medical profession in the field of public relations, particularly in its efforts made to enlighten the general public in connection with the A.M.A.'s methods, progress, and achievements and in pointing out that the public has a vital interest in the final result, and

WHEREAS, The National Physicians' Committee was a direct and vital influence during the past year in the defeat of the Murray-Wagner-Dingell Bill, and

WHEREAS, The National Physicians' Committee's continuance of the public relations program is definitely to the benefit of the medical profession and the public,

THEREFORE BE IT RESOLVED, That we, the House of Delegates of the Ohio State Medical Association, reaffirm our support of this all-physician institution and recommend that each and every component society of the Ohio State Medical Association cooperate with the National Physicians' Committee in its effective efforts dedicated, in the public interest, to preserving for doctors of medicine the distribution of medical service in the United States.

Resolution F. Introduced by A. J. Tronstein, Newark:

WHEREAS, In reviewing the Maternal Health Program of the Child Welfare Department as administered by the Ohio State Public Health Department under which wives of enlisted personnel of the Armed Services receive prenatal, obstetrical and postnatal care paid for by fees provided by the Federal Government, the Licking County Medical Society finds the following opinions to be a truthful expression by the Society:

1. The program was literally forced upon the medical profession with no regard for the desires or best opinions of either the medical profession or patients. Such forcible measures could easily be extended to almost any field in which medical services are used.
2. The program is wasteful of public funds, detrimental to public welfare, and financially unsound since it is not administered on a basis of need, but simply upon eligibility.
3. It is a political move whereby political goodwill is being built up in the public mind as being a generous gesture by the politician instead of being recognized a costly experiment in which the physician is the scapegoat.
4. It interposes a third party between the patient and doctor, thereby preventing the practice of true medicine.
5. The fee paid is being used as tempting bait to make socialized medicine appear more desirable to the American doctor; the eventual socialization of medicine being a huge method of exerting financial and political power for selfish interests rather than with any real wish to benefit suffering fellowmen.

THEREFORE BE IT RESOLVED, That the Licking County Medical Society in its regular business meeting held at Granville, Ohio, on January 25, 1944, asks that The Ohio State Medical Association take such steps as needed to repudiate any and all agreements with the Maternal Health Program of The Child Welfare Department as now operating through The Ohio Public Health Department, and that members of The Ohio State Medical Association shall not render medical services under the program unless all funds for such purposes be supplied on a need basis as established and administered by the respective relief organizations of the Army, Navy, Marine, and Air Force and/or The Red Cross.

Resolution G. Introduced by E. O. Swartz, Cincinnati:

WHEREAS, Rheumatic heart disease and rheumatic fever are now some of the foremost problems in public health, ranking high among the causes of death and disability, and

WHEREAS, Systematic efforts should be inaugurated in Ohio to bring these conditions under control, as has been done in a number of cities and states, notably Cincinnati and Chicago and Michigan and California, and

WHEREAS, Effective planning to combat these diseases requires knowledge of essential statistical facts regarding the diseases and the dissemination of such facts to the public and to professional groups in order to arouse their interest and to secure their cooperation, as control depends on good teamwork between the patients and their parents, physicians, teachers, nurses and social workers,

THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association recommends to the Ohio Public Health Council that rheumatic heart disease and rheumatic fever be added to the list of reportable diseases in Ohio in order that physicians and other interested persons may be supplied with vital statistical data in their efforts to organize programs of study and care in all communities of the state.

Resolution H. Introduced by G. A. Woodhouse, Pleasant Hill:

BE IT RESOLVED, That the House of Delegates officially endorses the action of The Council in recommending to the United States Congress that it enact legislation which would provide for distribution of benefits under the Emergency Maternity and Infant Care Program for the Wives and Infants of Servicemen on a cash allotment basis and in opposing the dictatorial policies and procedures of the U.S. Children's Bureau in administering the present program.

BE IT FURTHER RESOLVED, That the Board of Trustees of the American Medical Association be requested to make the proper arrangements for the presentation of a concrete plan embodying this principle to the Congress, to be substituted for the present program, in event the Congress decides to continue emergency maternity and infant care benefits to the wives and infants of enlisted men for the next fiscal year, starting July 1, 1944.

Resolution I. Introduced by A. A. Brindley, Toledo:

WHEREAS, The medical profession is conscious of its responsibilities in providing medical services to all of the American people, and

WHEREAS, The county societies throughout the State of Ohio are under continuous pressure to arrange for some plan to provide medical services on a prepaid basis, and

WHEREAS, There are plans in existence from which we have had the opportunity to learn from experience just what may be offered in and expected from prepayment plans,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association assume the responsibility of gathering data and facts on the operation of such plans as are now in existence, of keeping the information up to date, and of making it available to the component county societies.

Resolution J. Introduced by D. W. Heusinkveld, Cincinnati:

WHEREAS, The General Election to be held this year and the ensuing sessions of the United States Congress and the Ohio General Assembly will have an important bearing on the future social and economic life of the people of this state and of the entire nation, and

WHEREAS, Vital questions affecting the health of the people and the practice of medicine, including legislative proposals and governmental administrative policies, will undoubtedly arise during the coming year, and

WHEREAS, Physicians as individuals and as a group should be deeply concerned in seeing that only well-qualified persons are elected to the Congress, the Ohio General Assembly and other public offices and that those elected are acquainted with the views of the medical profession on medical and health questions,

THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association urges the officers and legislative committeemen of all county medical societies to take an active interest in the November election and to insist that all members of such societies do likewise in order that candidates may be fully informed of the views of the medical profession on medical and health issues; that members of the profession may be acquainted with the qualifications and views of the various candidates; and that the public-at-large may be encouraged to support those candidates whose record or capabilities qualify them for positions of public trust and confidence.

Resolution K. Introduced by F. W. Dixon, Cleveland:

WHEREAS, The uninterrupted flow of qualified students into medical schools is fundamental to the nation's health and welfare, and

WHEREAS, A directive issued April 11 by the National Selective Service System has been interpreted to mean that preprofessional students in medicine may be liable to early induction into the Army if they have not matriculated and engaged in actual classroom work in a medical school prior to July 1, 1944, and

WHEREAS, This would create additional burdens and handicaps for all medical schools and would seriously interfere with the continuous production of physicians,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association respectfully recommends to the National Selective Service System that it take immediate steps to modify this directive, if necessary, and establish a policy, in cooperation with the War and Navy Departments, which will insure qualified premedical students of uninterrupted classroom work.

Resolution L. Introduced by John M. Van Dyke, Canton:

WHEREAS, Congressman A. L. Miller, Nebraska, has introduced into the U. S. Congress a bill which would transfer all health activities of the Labor Department to the United States Public Health Service, including maternal and child health, crippled children's and industrial health programs, and

WHEREAS, Such transfer would promote better health activities and would eliminate overlapping and confusion, and

WHEREAS, The consolidation of the public health functions of the Federal Government under the supervision and direction of a single agency with trained personnel and adequate facilities would lead to administrative efficiency,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association approve in principle the policy underlying the proposal presented by Congressman Miller and that the Ohio members of the Congress be informed of this action on the part of the Association.

MISCELLANEOUS BUSINESS

On motion by Lewis W. Cellio, Carroll County, seconded by Chas. T. Atkinson, Butler County, and carried, the question of the time and place for the 1945 Annual Meeting was referred to The Council for decision at the appropriate time.

President Sherburne then introduced Colonel William S. Keller, Regional Medical Officer, Office of Civilian Defense, Chicago, who addressed the House of Delegates. Colonel Keller recommended that each county medical society continue with its present setup of emergency medical service as organized under the O.C.D. in order to keep this important activity within the hands of the medical profession. He pointed out that a large amount of valuable equipment will be available at the conclusion of the war and, if the medical profession maintains a proper emergency organization to serve local areas, it is quite likely that this equipment and material will be turned over to such organizations.

The Executive Secretary then read a communication received from Mr. Robert K. Dean, Recruiting Representative for the United States Civil Service Commission, asking the assistance of all physicians on the matter of obtaining personnel for various Civil Service positions. A sample of literature relative to present openings was made available to interested members of the House of Delegates.

There being no further business, the House of Delegates then recessed until 1:00 P.M., Thursday, May 4.

MINUTES OF THE SECOND SESSION

The second and final session of the House of Delegates, 98th Annual Meeting, was called to order by President Sherburne at 1:00 P. M., Thursday, May 4, Red Room, Neil House. The roll call showed 90 delegates present.

There being no unfinished business, the President then called for reports of the Reference Committees.

REPORT OF COMMITTEE ON PRESIDENTIAL ADDRESS

Dr. Robert Conard, Wilmington, chairman of the Reference Committee on Presidential Address, presented the following report of that committee:

"Your committee, after careful study of the President's Address, respectfully submits the following report:

"The Ohio State Medical Association has been fortunate in its leadership the past year, as evidenced by the sound thinking, calm deliberation and just conclusions so clearly expressed in the address of President Sherburne.

"One who has served us as President during this trying, eventful and critical year is in a position to understand the present situation of our profession more clearly than we as individuals are likely to view it.

"The very substantial accomplishments of the past year, with becoming modesty, are not presented in detail, but the membership is enjoined to careful study of the record as published in the committee reports in *The Ohio State Medical Journal.*

"The distinction drawn between progress and change is very timely indeed because of so much unrest and insecurity all about us. The danger of hasty, ill-considered change is in contrast to sound progress founded on basic principles.

"Looking forward to the period of readjustment which must follow wartime dislocations, we are advised of the principles which will enable us to meet the dangers of that time.

"First: Unity of action by the whole profession. Adherence to the policy that the American Medical Association be given full support through the free expression of opinion made known to it by members of the profession. Every member should have an active share in the deliberations and the decisions of his county society, and, by his elected representatives, in the actions and policies of state and national organized medicine.

"Second: Strengthening of this democratic mechanism by active participation of all members, correcting any deficiencies in our organization rather than criticizing it, or the setting up of multiple overlapping organizations devoted to the same purposes. Following the principles stated in the opening paragraphs of the address, logical agreements should be arrived at and a spirit of unity established. Calm, careful, logical, consistent action maintaining the traditional dignity of our profession, avoiding coercive arbitrary measures, will best serve the public interest and our own.

"The respect expressed for those serving in the Armed Forces and those working on the home front brings forth admiration for, and a spirit of devotion to, the leadership of our medical fraternity whose thoughts go out beyond personal horizons, and encompass all who are doing their best.

"Your committee endorses sincerely the plea for earnest, harmonious, concerted determination on our part to preserve here at home for our fellows abroad, the freedom and liberty they have a right to find when they return.

"We commend this able and scholarly review of the problems confronting us to the thoughtful consideration of every member of this Association.

"To give our leadership comfort and support is not too big a job for any one of us."

On motion by Dr. Conard, seconded by S. J. Podlewski, Jefferson County, and carried, the

report of the Reference Committee on Presidential Address was approved.

REPORT OF COMMITTEE ON ANNUAL REPORTS

The report of the Reference Committee on Annual Reports was presented by Chas. T. Atkinson, Middletown, chairman. The report read as follows:

"The respective chairmen of the hereinafter designated committees have made their detailed reports which have been published in the April 1, 1944, issue of *The Ohio State Medical Journal.* However, the chairman feels that it is proper to submit at this time a resume of the aforesaid reports for the benefit of the convention.

"**1. Committee on Public Relations and Economics.** As you no doubt know, The Council has disapproved the proposal of the United States Children's Bureau for an Emergency Maternity and Infant Care Program. Notwithstanding this disapproval a great many physicians are participating for reasons known only to them. We feel that many are doing so because of some patriotic spirit. However, it is the sense of the committee that the proposal of the Children's Bureau is unsound in principle. If the proposal reaches maturity it will act as a wedge to divide the medical profession from one of private practice to one of governmental function to the point when initiative will be relegated to the whim of bureaucratic edict. We can not help but feel that we are gradually being forced into a state of national socialism by the various acts of legislation which on their surface claim to benefit mankind as a whole; and unless we vigorously oppose such legislation, both present and future, we will be lulled into the practice of governmental medicine.

"The committee feels that the medical profession should progress, not radically, but soundly with the view in mind of doing those things that will benefit the greatest multitude of our citizens, by supplying medical and health services by improved methods. Governmental direction is not a guarantee, nor will it take the place of the development of better methods. We feel that safe and sane cooperation between private enterprise, the public and the government will do the job. The Committee on Public Relations is constantly conferring with both state and governmental agencies, with the view in mind of working out social benefits in the field of medicine for the improvement of our national health.

"**2. Committee on War Participation.** This committee has served a two-fold purpose, acting as the Committee on War Participation and also as the Ohio Procurement and Assignment Committee for Physicians. Our ranks are being continually depleted by the great conflict that has enveloped this world to the extent that serious local problems have arisen in some communities as regards the provision of necessary medical attention to the civilian population. Notwithstanding this, Ohio can well feel proud of the job it is doing both on the battle front and on the home front in the energetic manner in which it is distributing its medical manpower. The demands on us will continue in the future to an extent not fully known to us at this time, and increased demands will be made upon hospitals, medical schools, institutions and doctors. Staffs will be curtailed to a greater extent. Doctors will have to be shifted to places when greater emergencies exist. Yet we are energetic enough to meet the emergency. We will have to curtail some of the activities that sap our strength which do not give greater service to the greatest number of our civilian population. Our motto now must be 'The greatest service for the greatest number'.

"**3. Committee on Education.** The life blood of our profession is the proper education of our incoming doctors and the constant semination of new methods to our practitioners. With this in mind the Committee on Education is working on plans with the various medical schools and hospitals to provide for such training to new men and for refresher courses for our practitioners both on the battlefield and those at home. The committee feels that such actual training must be relegated to such time as the great emergency is over. Their planning is taking definite form and will be ready to be placed in operation at the opportune time. The committee is confining its activities for the present to assembling data regarding postgraduate educational facilities, to preparing plans for expansion of such facilities, and to coordination and organization of the activities of the medical schools, hospitals and the State Association in this important field.

"**4. Committee on Industrial Health.** This committee is doing a wonderful piece of work in a field that has expanded tremendously since the inception of the war. It has been responsible for the creation, in practically all of the industrial communities of Ohio, of a county committee on industrial health. The committee with intelligence and foresight realizing that conditions vary with each community has evolved plans which were flexible and practicable in their respective applications. From the outset it has aspired to the awakening of the profession in Ohio to the need for medical leadership in meeting the health problems of industry, not only as another contribution of physicians to the war effort, but as a sound basis on which to plan for the health problems of the worker in normal times.

Numerous conferences have been held; many speakers and lecturers of renoun in this field have been engaged and the addresses have been well-attended and received. We feel that these addresses which will appear in an early issue of *The Ohio State Medical Journal,* are worthwhile and should be read by every Ohio physician.

A sub-committee of this committee has been created by President Sherburne known as the Committee on Workmen's Compensation which has been very active and has been in constant contact with the Industrial Commission of Ohio making various recommendations to it with the hope of revising the Fee Schedule which is in existence at present and which in a great many instances is obsolete in the face of present-day conditions. Great progress has been achieved, and in the future a well-balanced fee schedule will result. Although these committees have not completed their work, a final report will be furnished to The Council for review and approval in due course.

"**5. Committee on Auditing and Appropriations and the Treasurer.** It is apparent from the audit of the books of the Ohio State Medical Association and *The Ohio State Medical Journal,* that they are both sound financially and that the officers and managers thereof have done a splendid job in their respective capacities. They are to be heartily congratulated. Although revenues will be reduced, we will be able to carry on in

the same efficient manner as in the past. However, let us not shirk our duties—pay up, everybody."

On motion by Dr. Atkinson, seconded by D. J. Slosser, Defiance County, and carried, the report of the Reference Committee on Annual Reports was approved.

REPORT OF COMMITTEE ON RESOLUTIONS

G. A. Woodhouse, Pleasant Hill, chairman of the Reference Committee on Resolutions, presented the report of his committee as follows:

"The Reference Committee on Resolutions, appointed by President Sherburne at the first session of the House of Delegates on Tuesday, May 2, has held several meetings and has given careful consideration to the twelve resolutions presented to the House of Delegates and referred to this committee for study and recommendation. The committee was gratified to have so many members of the House of Delegates appear before it to discuss the various resolutions and to present information which was very helpful to the committee in its deliberations. Your commitee presents the following report and recommendations on the various resolutions.

Resolution A

"Resolution A, presented by Robert Conard, Clinton County, read as follows:

> "BE IT RESOLVED by the House of Delegates of the Ohio State Medical Association in session in Columbus, Ohio, May 2, 3 and 4, 1944:
>
> "1. That the Board of Trustees of the American Medical Association be commended for having authorized the opening of an office in Washington, D. C., as recommended a year ago by this Association;
>
> "2. That the Board of Trustees be urged to maintain at all times an appropriation which will be adequate to provide competent personnel for the Washington office and enable that office to carry on its important activities efficiently and expeditiously;
>
> "3. That the Ohio State Medical Association express itself as believing that the American Medical Association is the proper organization to represent the medical profession of this country on legislative matters and questions pertaining to health and medical activities of all departments and agencies of the Federal Government, as well as similar activities of national unofficial and voluntary groups and organizations;
>
> "4. That this Association believes that there is no necessity for the maintenance and formation of independent organizations, composed of physicians and financed by physicians, for the purposes referred to in the foregoing paragraph, for the reason that the American Medical Association has the potential resources, facilities and ability to provide efficient leadership on such matters if the potentialities of the American Medical Association were to be fully developed;
>
> "5. That the Ohio State Medical Association pledges its active cooperation to the end that the potential strength of the American Medical Association shall be fully developed and instructs its delegates to the American Medical Association to support proposals which in their opinion would improve and strengthen the American Medical Association so it will be able to fully discharge its responsibilities and meet its obligations during the uncertain period which lies ahead.

"This resolution was given a great deal of study and it is the opinion of the committee that the purpose of the original resolution would be carried out through the adoption of the following substitute resolution and the committee recommends the adoption of the substitute resolution:

Substitute Resolution A

> "BE IT RESOLVED by the House of Delegates of the Ohio State Medical Association in session in Columbus, Ohio, May 2, 3 and 4, 1944:
>
> "1. That the Board of Trustees of the American Medical Association be commended for having authorized the opening of an office in Washington, D. C., as recommended a year ago by this Association;
>
> "2. That the Board of Trustees be urged to maintain at all times an appropriation which will be adequate to provide competent personnel for the Washington office and enable that office to carry on its important activities efficiently and expeditiously;
>
> "3. That the Ohio State Medical Association express itself as believing that the American Medical Association is the proper organization to represent the medical profession of this country on legislative matters and questions pertaining to health and medical activities of all departments and agencies of the Federal Government, as well as similar activities of national unofficial and voluntary groups and organizations;
>
> "4. That the Ohio State Medical Association pledges its active cooperation to the end that the potential strength of the American Medical Association shall be fully developed and instructs its delegates to the American Medical Association to support proposals which in their opinion would improve and strengthen the American Medical Association so it will be able to fully discharge its responsibilities and meet its obligations during the uncertain period which lies ahead."

On motion by Dr. Woodhouse, seconded by Wm. M. Skipp, Mahoning County, and carried, the recommendation of the committee that Substitute Resolution A be adopted was approved.

Resolution B

"Resolution B, presented by Louis N. Jentgen, Franklin County, read as follows:

> "WHEREAS, A special commission authorized by the Ninety-Fifth Ohio General Assembly is making an exhaustive study of the salaries and wages paid to state employes, and
>
> "WHEREAS, There is evidence that the salaries paid to many classes of state employes are not commensurate with the work performed and the responsibilities such employes must assume, and

"WHEREAS, This situation is especially acute with respect to employes who must possess professional, scientific and technical education and training, notably physicians, attorneys, engineers, nurses, technicians, and those holding important administrative positions, and

"WHEREAS, It is becoming increasingly difficult for the state government to acquire the services of a sufficient number of professionally-trained employes for essential positions because of the low-salary schedules of the state as compared to the income which can be derived through private practice or employment elsewhere,

"THEREFORE BE IT RESOLVED, That this Association request those elected to the next General Assembly to give serious consideration to recommendations which may be submitted, revising upward the salaries paid by the State of Ohio to physicians and others who must be especially qualified for their duties.

"The committee felt that a slight change in the wording of the resolution would be desirable and, therefore, **recommends the adoption of the following substitute resolution:**

Substitute Resolution B

"WHEREAS, A special commission authorized by the Ninety-Fifth Ohio General Assembly is making an exhaustive study of the salaries and wages paid to state employes, and

"WHEREAS, There is evidence that the salaries paid to many classes of state employes are not commensurate with the work performed and the responsibilities such employes must assume, and

"WHEREAS, This situation is especially acute with respect to employes who must possess professional, scientific and technical education and training, notably physicians, attorneys, engineers, nurses, technicians, and those holding important administrative positions, and

"WHEREAS, It is becoming increasingly difficult for the state government to acquire the services of a sufficient number of professionally-trained employes for essential positions because of the low-salary schedules of the state as compared to the income which can be derived through private practice or employment elsewhere,

"THEREFORE BE IT RESOLVED, That this Association request those elected to the next General Assembly to give serious consideration to recommendations which may be submitted, revising upward the salaries paid by the State of Ohio to employes in the above-mentioned group."

On motion by Dr. Woodhouse, seconded by Robert Conard, Clinton County, and carried, the recommendation of the committee, recommending the adoption of Substitute Resolution B, was approved.

Resolution C

"Resolution C, presented by Wm. M. Skipp, Mahoning County, which re-affirms the policy of The Council of the Ohio State Medical Association with respect to the Wagner-Murray-Dingell Bill and on the question of voluntary prepayment medical service plans has the hearty approval of your committee and **its adoption is recommended.** It reads as follows:

"WHEREAS, The Council of the Ohio State Medical Association has issued a forceful, sound and intelligent statement in opposition to the enactment of the Wagner-Murray-Dingell compulsory sickness insurance bill, now pending in the Congress, and

"WHEREAS, The Council's statement emphasizes that the program proposed by the Wagner Bill would be detrimental, rather than beneficial, to the health and welfare of the American people and that a revolutionary plan of that kind is not necessary to bring about additional improvements in the health of the people of this country,

"BE IT RESOLVED by the House of Delegates of the Ohio State Medical Association, in session May 2, 3 and 4, 1944, in Columbus, Ohio:

"1. That the statement issued by The Council on the Wagner-Murray-Dingell Bill be officially endorsed and The Council and the Committee on Public Relations be commended for their action in opposing this proposal;

"2. That the officers and legislative committmen, especially, and all members of component medical societies of this Association be urged to actively support The Council, the Committee on Public Relations and the Legislative Committee of the Association in their efforts to disseminate information regarding the Wagner Bill to the people of Ohio;

"3. That the medical profession of Ohio through county medical societies take immediate steps to initiate voluntary prepayment medical service plans under the provisions of the Ohio Enabling Act for Medical Service Plans for the purpose of improving the health of the citizens of Ohio, of assisting low-wage earners to budget the costs of medical care, and of making the benefits of modern medical services more readily available to those with limited incomes;

"4. That the medical profession, individually and collectively, also encourage and actively support other local and state programs and activities which will promote further progress in the improvement of the health of the people of this state and will result in safe and sane cooperation between private enterprise, the public and the government;

"5. That the medical profession of Ohio be urged specifically to cooperate with other interested, dependable groups and agencies in:

"Attacking the causes of unemployment and disability;

"Encouraging self-protection through thrift, savings and private insurance;

"Maintaining a sound, conservative Social Security Program, the efforts of which would be directed toward meeting contingencies which can not be met through private enterprise rather than in placing emphasis upon paying citizens for being unemployed and sick;

"Improving social, economic and working conditions generally;

"Expanding present programs for improvement of food, housing, recreation and

other environmental conditions influencing health;

"Expanding present programs of health education;

"Improving present local and state programs providing medical and hospital care for the poor;

"Improving present programs providing care for and rehabilitation of the handicapped and permanently disabled;

"Expanding existing local and state public health programs to meet proven needs;

"Emphasizing the importance of financial responsibility on the part of local and state governments—taxpayers generally—in those health activities which are the proper functions of government;

"Maintaining a major portion of administrative control in the hands of local officials and groups to insure a greater degree of efficiency, economy and responsibility;

"Accepting the assistance of the Federal Government in an advisory capacity but refusing to yield to Washington bureaucracy on matters which can and should be handled by private enterprise and by local and state governmental agencies;

"Expanding hospital facilities when and where needed but assuring administration will be unhampered by political domination;

"Increasing the number of beneficiaries of voluntary hospitalization plans."

On **motion** by Dr. Woodhouse, seconded by D. J. Slosser, Defiance County, and **carried**, the recommendation of the committee endorsing Resolution C was **approved.**

Resolution D

"Resolution D, presented by Harry E. LeFever, Franklin County, read as follows:

"WHEREAS, The Hon. John W. Bricker will retire as Governor of the State of Ohio at the conclusion of his present term, and

"WHEREAS, Governor Bricker during his three terms as Chief Executive of Ohio has taken a leading part in promoting the health and welfare of the citizens of this state by encouraging the formation of sound and beneficial health and medical programs; by appointing qualified and dependable physicians for administrative duties; by seeking the advice and counsel of the medical profession on medical and health questions; and by opposing proposals which would be detrimental to the health and welfare of the people of Ohio,

"THEREFORE BE IT RESOLVED, That the Ohio State Medical Association, on behalf of the medical profession of this state, officially commend Governor Bricker for his sound attitude on medical and health questions and for his vigorous and outspoken opposition to proposals which would lower health and medical standards, weaken present public health laws and administrative procedures, and destroy the private practice of medicine.

"BE IT FURTHER RESOLVED, That this Association express to Governor Bricker sincere appreciation for the numerous opportunities he has given representatives of the medical profession to confer and counsel with him on questions in which the physicians of Ohio are deeply interested and which have been of vital interest to the health of the citizens of our state.

"Your Reference Committee on Resolutions approves the sentiments expressed in this resolution and **recommends its adoption.**"

On **motion** by Dr. Woodhouse, seconded by John M. Thomas, Franklin County, and **carried**, the recommendation of the committee endorsing Resolution D was **approved.**

Resolution G

"Resolution G, presented by E. O. Swartz, Hamilton County, read as follows:

"WHEREAS, Rheumatic heart disease and rheumatic fever are now some of the foremost problems in public health, ranking high among the causes of death and disability, and

"WHEREAS, Systematic efforts should be inaugurated in Ohio to bring these conditions under control, as has been done in a number of cities and states, notably Cincinnati and Chicago and Michigan and California, and

"WHEREAS, Effective planning to combat these diseases requires knowledge of essential statistical facts regarding the diseases and the dissemination of such facts to the public and to professional groups in order to arouse their interests and to secure their cooperation, as control depends on good teamwork between the patients and their parents, physicians, teachers, nurses and social workers,

"THEREFORE BE IT RESOLVED That the Ohio State Medical Association recommends to the Ohio Public Health Council that rheumatic heart disease and rheumatic fever be added to the list of reportable diseases in Ohio in order that physicians and other interested persons may be supplied with vital statistical data in their efforts to organize programs of study and care in all communities of the state.

"Your committee **recommends the adoption** of this resolution."

On **motion** by Dr. Woodhouse, seconded by Waite Adair, Lorain County, and **carried**, the recommendation of the committee endorsing Resolution G was **approved.**

Resolution H

"Resolution H, presented by G. A. Woodhouse, Miami County, read as follows:

"BE IT RESOLVED, That the House of Delegates officially endorses the action of The Council in recommending to the United States Congress that it enact legislation which would provide for distribution of benefits under the Emergency Maternity and Infant Care Program for the Wives and Infants of Servicemen on a cash allotment basis and in opposing the dictatorial policies and procedures of the U.S. Children's Bureau in administering the present program.

"BE IT FURTHER RESOLVED, That the Board of Trustees of the American Medical Association be requested to make the proper arrangements for the presentation

of a concrete plan embodying this principle to the Congress, to be substituted for the present program, in event the Congress decides to continue emergency maternity and infant care benefits to the wives and infants of enlisted men for the next fiscal year, starting July 1, 1944.

"This resolution has the approval of the committee and the committee **recommends its adoption.**"

On **motion** by Dr. Woodhouse, seconded by Guy E. Noble, Auglaize County, and **carried**, the recommendation of the committee endorsing Resolution H was **approved.**

Resolution I

"Resolution I, presented by A. A. Brindley, Lucas County, read as follows:

"WHEREAS, The medical profession is conscious of its responsibilities in providing medical services to all of the American people, and

"WHEREAS, The county societies throughout the State of Ohio are under continuous pressure to arrange for some plan to provide medical services on a prepaid basis, and

"WHEREAS, There are plans in existence from which we have had the opportunity to learn from experience just what may be offered in and expected from prepayment plans,

THEREFORE BE IT RESOLVED, That the Ohio State Medical Association assume the responsibility of gathering data and facts on the operation of such plans as are now in existence keeping the information up to date, and of making it available to the component county societies.

"The purpose of this resolution is highly commendable in the opinion of your Reference Committee. **In recommending its adoption** the committee makes the following additional recommendation; namely: That The Council of the Ohio State Medical Association be urged to recreate a Committee on Medical Service Plans to assist in carrying out the suggestions contained in the resolution."

On **motion** by Dr. Woodhouse, seconded by E. P. Sparks, Auglaize County, and **carried**, the recommendation of the committee endorsing Resolution I was **approved.**

Resolution J

"Resolution J was presented by D. W. Heusinkveld, Hamilton County, and it read as follows:

"WHEREAS, The General Election to be held this year and the ensuing sessions of the United States Congress and the Ohio General Assembly will have an important bearing on the future social and economic life of the people of this state and of the entire nation, and

"WHEREAS, Vital questions affecting the health of the people and the practice of medicine, including legislative proposals and governmental administrative policies, will undoubtedly arise during the coming year, and

"WHEREAS, Physicians as individuals and as a group should be deeply concerned in seeing that only well-qualified persons are elected to the Congress, the Ohio General Assembly and other public offices and that those elected are acquainted with the views of the medical profession on medical and health questions,

"THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association urges the officers and legislative committeemen of all county medical societies to take an active interest in the November election and to insist that all members of such societies do likewise in order that candidates may be fully informed of the views of the medical profession on medical and health issues; that members of the profession may be acquainted with the qualifications and views of the various candidates; and that the public-at-large may be encouraged to support those candidates whose record or capabilities qualify them for positions of public trust and confidence.

"Your committee agrees with the suggestions and recommendations made in the resolution and urges **its adoption** by the House of Delegates."

On **motion** by Dr. Woodhouse, seconded by Charles R. Meek, Lorain County, and **carried**, the recommendation of the committee endorsing Resolution J was **approved.**

Resolution K

"Resolution K, presented by F. W. Dixon, Cuyahoga County, read as follows:

"WHEREAS, The uninterrupted flow of qualified students into medical schools is fundamental to the nation's health and welfare, and

"WHEREAS, A directive issued April 11 by the National Selective Service System has been interpreted to mean that preprofessional students in medicine may be liable to early induction into the Army if they have not matriculated and engaged in actual classroom work in a medical school prior to July 1, 1944, and

"WHEREAS, This would create additional burdens and handicaps for all medical schools and would seriously interfere with the continuous production of physicians,

"THEREFORE BE IT RESOLVED, That the Ohio State Medical Association respectfully recommends to the National Selective Service System that it take immediate steps to modify this directive, if necessary, and establish a policy, in cooperation with the War and Navy Departments, which will insure qualified premedical students of uninterrupted classroom work.

"Since the uninterrupted flow of qualified students into medical schools is of vital necessity and because this has been seriously impeded by the war emergency, the committee believes that prompt steps should be taken to correct this situation as suggested in the resolution and, therefore, **recommends the adoption** of Resolution K."

On **motion** by Lewis W. Cellio, Carroll County, seconded by Wm. M. Skipp, Mahoning County, and **carried**, the words "Armed Forces" were substituted for the word "Army" in the second paragraph of the resolution.

On **motion** by Dr. Woodhouse, seconded by R. L. Rutledge, Stark County, and **carried**, the recommendation of the committee endorsing the resolution, as amended, was **approved.**

Resolution L

"Resolution L, presented by John M. Van Dyke, Stark County, read as follows:

> "WHEREAS, Congressman A. L. Miller, Nebraska, has introduced into the U. S. Congress a bill which would transfer all health activities of the Labor Department to the United States Public Health Service, including maternal and child health, crippled children's and industrial health programs, and
>
> "WHEREAS, Such transfer would promote better health activities and would eliminate overlapping and confusion, and
>
> "WHEREAS, The consolidation of the public health functions of the Federal Government under the supervision and direction of a single agency with trained personnel and adequate facilities would lead to administrative efficiency,
>
> "THEREFORE BE IT RESOLVED, That the Ohio State Medical Association approve in principle the policy underlying the proposal presented by Congressman Miller and that the Ohio members of the Congress be informed of this action on the part of the Association.

"The legislative proposal referred to in Resolution L is in line with the present policy of the American Medical Association. Inasmuch as it would consolidate present health activities of the Federal Government in the proper department and undoubtedly would lead to greater efficiency, your Reference Committee **recommends the adoption** of the resolution."

On **motion** by Dr. Woodhouse, seconded by James A. Beer, Franklin County, and **carried**, the recommendation of the committee endorsing Resolution L was **approved.**

Resolution F

"Resolution F, presented by A. J. Tronstein, Licking County, read as follows:

> "WHEREAS, In reviewing the Maternal Health Program of the Child Welfare Department as administered by the Ohio State Public Health Department under which wives of enlisted personnel of the Armed Services receive prenatal, obstetrical and postnatal care paid for by fees provided by the Federal Government, the Licking County Medical Society finds the following opinions to be a truthful expression by the Society:
>
> "1. The program was literally forced upon the medical profession with no regard for the desires or best opinions of either the medical profession or patients. Such forcible measures could easily be extended to almost any field in which medical services are used.
>
> "2. The program is wasteful of public funds, detrimental to public welfare, and financially unsound since it is not administered on a basis of need, but simply upon eligibility.
>
> "3. It is a political move whereby political goodwill is being built up in the public mind as being a generous gesture by the politician instead of being recognized a costly experiment in which the physician is the scapegoat.
>
> "4. It interposes a third party between the patient and doctor, thereby preventing the practice of true medicine.
>
> "5. The fee paid is being used as tempting bait to make socialized medicine appear more desirable to the American doctor; the eventual socialization of medicine being a huge method of exerting financial and political power for selfish interests rather than with any real wish to benefit suffering fellowmen.
>
> "THEREFORE BE IT RESOLVED, That the Licking County Medical Society in its regular business meeting held at Granville, Ohio, on January 25, 1944, asks that the Ohio State Medical Association take such steps as needed to repudiate any and all agreements with the Maternal Health Program of The Child Welfare Department as now operating through the Ohio Public Health Department, and that members of The Ohio State Medical Association shall not render medical services under the program unless all funds for such purposes be supplied on a need basis as established and administered by the respective relief organizations of the Army, Navy, Marine and Air Force and/or The Red Cross.

"The purpose of this resolution is commendable in the opinion of your committee. However, your committee believes that the objectives of this resolution could be better accomplished under the procedure set forth in Resolution H (which the House of Delegates has already adopted). Therefore, your committee **recommends that Resolution F be not adopted."**

Dr. Woodhouse moved the adoption of the recommendation of the committee and the motion was duly seconded by D. A. Berndt, Scioto County. Dr. A. J. Tronstein, Licking County, then addressed the House of Delegates, urging the rejection of the recommendation of the Reference Committee and the adoption of the resolution. **By a standing vote of 44 to 28 the House of Delegates adopted the motion that the recommendation of the Reference Committee be adopted, namely, that Resolution F be rejected.**

Resolution E

"Resolution E, presented by F. N. Nagel, Lucas County, read as follows:

> "WHEREAS, The National Physicians' Committee for the extension of medical service has thoroughly proved its value to the medical profession in the field of public relations, particularly in its efforts made to enlighten the general public in connection with the A.M.A.'s methods, progress, and achievements and in pointing out that the

public has a vital interest in the final result, and

"WHEREAS, The National Physicians' Committee was a direct and vital influence during the past year in the defeat of the Murray-Wagner-Dingell Bill, and,

"WHEREAS, The National Physicians' Committee's continuance of the public relations program is definitely to the benefit of the medical profession and the public,

"THEREFORE BE IT RESOLVED, That we, the House of Delegates of the Ohio State Medical Association, reaffirm our support of this all-physician institution and recommend that each and every component society of the Ohio State Medical Association cooperate with the National Physicians' Committee in its effective efforts dedicated, in the public interest, to preserving for doctors of medicine the distribution of medical service in the United States.

"It is the opinion of your committee that this question was thoroughly considered by the House of Delegates at the 1943 Annual Meeting, at which time the House of Delegates approved the policy as set forth in actions of The Council; namely: That affiliation with the National Physicians' Committee is a matter to be decided individually by members of the medical profession. Your committee believes that there is no need for a change in that policy at this time and, therefore, **recommends that Resolution E be not adopted.**"

On **motion** by Dr. Woodhouse, seconded by John H. Mitchell, Franklin County, and **carried, the recommendation of the committee that Resolution E be not adopted was approved.**

On **motion** by Dr. Woodhouse, seconded by D. A. Berndt, Scioto County, and **carried,** the report of the Reference Committee as a whole, as amended, was **approved.**

At this point Edward J. McCormick, Lucas County, was recognized by the chair and he moved that the House of Delegates commend the Licking County Medical Society for the sentiments expressed in Resolution F, which had been rejected, and that Dr. Tronstein be commended for his very able presentation of the views of that society in support of the resolution. The motion was seconded by Chas. W. Pavey, Franklin County, and given an affirmative vote by the House of Delegates.

ELECTION OF THE PRESIDENT-ELECT

At this point President Sherburne called for nominations from the floor for the office of President-Elect.

Wm. M. Skipp, Youngstown, presented the name of **Edgar P. McNamee,** Cleveland, retiring member of The Council representing the Fifth Councilor District. The nomination was seconded by D. W. Hogue, Springfield.

There being no further nominations, on **motion** by H. C. Rosenberger, Cleveland, seconded by M. Paul Motto, Cleveland, and **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous vote of the House of Delegates for **Dr. McNamee as President-Elect.** This was done and Dr. McNamee was elected.

Dr. McNamee was officially presented to the House of Delegates at this time. He made a brief address stating that with the help of members of The Council, committeemen, House of Delegates and members generally, he would endeavor to carry on the essential work of the office and to further the activities started by his predecessors.

REPORT OF COMMITTEE ON NOMINATIONS

The following names were placed in nomination by D. W. Heusinkveld, Cincinnati, chairman of the Committee on Nominations:

For Councilors for the odd-numbered Districts for **a two-year term:**

First District—E. O. Swartz, Cincinnati, to succeed himself.

Third District—Guy E. Noble, St. Marys, to succeed himself.

Fifth District—Fred W. Dixon, Cleveland, to succeed Edgar P. McNamee, Cleveland, elected President-Elect.

Seventh District—Carl A. Lincke, Carrollton, to succeed himself.

Ninth District — Gilbert Micklethwaite, Portsmouth, to succeed himself.

Eleventh District—Ross M. Knoble, Sandusky, to succeed himself.

For Delegates and Alternates to the American Medical Association to serve for the years 1944 and 1945:

G. A. Woodhouse, Pleasant Hill, to succeed himself as delegate.

Carl A. Lincke, Carrollton, to succeed R. S. Binkley, Dayton, as alternate.

Edward J. McCormick, Toledo, to succeed himself as delegate.

H. M. Platter, Columbus, to succeed himself as alternate.

Harry V. Paryzek, Cleveland, to succeed himself as delegate.

Charles R. Meek, Lorain, to succeed himself as alternate.

Carl R. Steinke, Akron, to succeed himself as delegate.

D. J. Slosser, Defiance, to succeed himself as alternate.

For one Delegate and one Alternate to the American Medical Association to serve for the year 1944, being the eighth delegate and alternate to which Ohio is now entitled under reapportionment:

C. C. Sherburne, Columbus, as delegate.
George T. Harding, Columbus, as alternate.

There being no nominations from the floor for the offices of Councilor, on **motion** by Lewis W. Cellio, Carrollton, seconded by S. J. Podlewski, Steubenville, and **carried**, the nominations were closed and the Secretary was instructed to cast the ballot of the House of Delegates for the six nominees presented by the committee for the office of Councilor. This being done, President Sherburne **officially declared such nominees duly elected** to The Council for a term of two years.

There being no nominations from the floor for the offices of delegate and alternate to the American Medical Association, on **motion** by F. N. Nagel, Toledo, seconded by D. C. Houser, Urbana, and **carried**, the Secretary was instructed to cast the ballot of the House of Delegates for the nominees for delegate and alternate presented by the committee. This being done, President Sherburne **declared such nominees as duly elected** for the terms specified by the committee.

INSTALLATION OF NEW PRESIDENT

At this point President Sherburne presented the official gavel of the Ohio State Medical Association to L. Howard Schriver, Cincinnati, and installed him as President of the Association for the year 1944-1945.



L. H. SCHRIVER, M.D.

In addressing the House of Delegates Dr. Schriver stated that it was his sincere intention to make the Ohio State Medical Association as dynamic as possible and among other things to:

(1) Encourage unity of action on the part the medical profession of Ohio and lend support and offer constructive criticism to the American Medical Association in its activities in order that the ideals and freedom of the medical profession might be maintained and protected.

(2) Stimulate interest in and disseminate information to the members of the Ohio State Medical Association on all legislative and similar questions involving the health and welfare of the people of Ohio and the interests of the physicians of Ohio.

(3) Formulate a practical program to provide educational facilities for physicians returning from military services and for physicians now in civilian practice.

(4) Energetically and intelligently encourage the establishment of voluntary prepayment medical service plans in conformity with the provisions of the Ohio Enabling Act.

Dr. Schriver expressed the hope that all members of the House of Delegates and members generally would call upon him as President at any time when he and the facilities of his office and the State Headquarters Office could be of service, not only to county medical societies, but also to individual members.

APPOINTMENT OF COMMITTEES

Dr. Schriver then appointed the following members to the standing committees for terms of five years:

Committee on Public Relations and Economics—Barney J. Hein, Toledo, to succeed himself as a member of the committee for a term of five years and to serve as chairman for the ensuing year.

Committe on Education—R. S. Fidler, Columbus, to serve as a member of the committee for a term of five years. **Carl A. Wilzbach**, Cincinnati, now a member of the committee, to serve as chairman for the ensuing year.

Judicial and Professional Relations Committee — John A. Caldwell, Cincinnati, to serve as a member of the committee for a term of five years. **James G. Kramer**, Akron, now a member of the committee, to serve as chairman for the ensuing year.

Committee on Scientific Work—M. Paul Motto, Cleveland, to serve as a member of the committee for a term of five years. **Charles A. Doan**, Columbus, now a member of the committee, to serve as chairman for the ensuing year.

On **motion** by Wm. M. Skipp, Youngstown, seconded by A. A. Brindley, Toledo, and **carried**, the foregoing committee appointments **were officially confirmed** by the House of Delegates.

There being no further business, the House of Delegates adjourned sine die.

Attest: CHARLES S. NELSON,
Executive Secretary

House of Delegates Roll Call
98th Annual Meeting

County	Delegate	First Session	Second Session
Adams	R. B. Ellison	———	present
Allen	E. C. Yingling	present	———
Ashland	R. P. Bogniard	present	present
Ashtabula	P. J. Collander	present	present
Athens	H. H. Fockler	———	———
Auglaize	E. P. Sparks	present	present
Belmont	C. W. Lose	present	———
Brown	———	———	———
Butler	Chas. T. Atkinson	present	present
Carroll	Lewis W. Cellio	present	present
Champaign	D. C. Houser	present	present
Clark	D. W. Hogue	present	present
Clermont	F. S. Skeen	present	present
Clinton	Robert Conard	present	present
Columbiana	J. A. Fraser	present	present
Coshocton	H. W. Lear	present	———
"	F. W. Craig	———	present
Crawford	C. A. Marquart	———	———
Cuyahoga	M. Paul Motto	present	present

County	Delegate	First Session	Second Session
Cuyahoga	J. N. Wychgel	present	present
"	H. C. Rosenberger	present	present
"	F. T. Gallagher	present	present
"	R. J. Whitacre	present	----------
"	B. B. Sankey	present	----------
"	J. W. McCall	present	----------
"	F. W. Dixon	present	present
"	H. V. Phelan	present	present
"	Harold Feil	present	----------
"	I. H. Einsel	----------	present
"	Ralph M. Watkins	----------	present
"	H. K. Giffen	----------	present
Darke	C. I. Stephen	present	----------
Defiance	D. J. Slosser	present	present
Delaware	E. V. Arnold	----------	----------
Erie	V. A. Killoran	present	----------
"	E. J. Meckstroth	----------	present
Fairfield	C. P. Swett	present	present
Fayette	J. H. Persinger	present	present
Franklin	Charles W. Pavey	present	present
"	John M. Thomas	present	present
"	John H. Mitchell	present	present
"	Louis N. Jentgen	present	----------
"	James A. Beer	present	present
Fulton	----------	----------	----------
Gallia	F. W. Shane	present	present
Geauga	H. E. Shafer	present	present
Greene	C. G. McPherson	present	present
Guernsey	F. W. Lane	present	present
Hamilton	Ralph W. Eddy	----------	present
"	Robert C. Rothenberg	present	present
"	Joseph Lindner	present	present
"	Emil R. Swepston	present	present
"	E. A. Kindel	present	----------
"	Lloyd B. Johnston	present	present
"	H. H. Shook	present	----------
"	D. W. Heusinkveld	present	present
Hancock	Frank M. Wiseley	----------	----------
Hardin	R. G. Schutte	----------	----------
Harrison	Carl F. Goll	present	present
Henry	J. J. Harrison	----------	----------
Highland	H. W. Chaney	----------	----------
Hocking	----------	----------	----------
Holmes	J. C. Elder	present	present
Huron	R. A. Blackman	present	----------
Jackson	W. B. Taylor	----------	----------
Jefferson	S. J. Podlewski	present	present
Knox	F. C. Anderson	----------	present
Lake	V. N. Marsh	present	----------
Lawrence	Heber W. Johnson	present	present
Licking	Arthur J. Tronstein	present	present
Logan	C. J. Bondley	----------	----------
Lorain	Charles R. Meek	present	present
"	Waite Adair	present	present
Lucas	F. N. Nagel	present	present
"	R. C. Young	present	present
"	L. D. Miller	present	present
"	C. S. Mundy	present	present
Madison	----------	----------	----------
Mahoning	J. N. McCann	present	present
"	Wm. M. Skipp	present	present
"	E. J. Reilly	present	present
Marion	C. J. Altmaier	----------	----------
Medina	F. C. Reuter	present	present
Meigs	----------	----------	----------
Mercer	Charles P. Adkins	----------	----------
Miami	G. A. Woodhouse	present	present
Monroe	A. R. Burkhart	----------	----------
Montgomery	R. S. Binkley	present	present
"	M. R. Haley	present	----------
"	R. D. Dooley	----------	present
"	M. D. Prugh	----------	present
Morgan	C. E. Northrup	----------	----------
Morrow	F. M. Hartsook	present	present
Muskingum	M. A. Loebell	present	----------
Noble	----------	----------	----------
Ottawa	F. E. Miller	present	present
Paulding	D. E. Farling	present	----------
Perry	James Miller	----------	----------
Pickaway	A. D. Blackburn	present	----------
Pike	L. E. Wills	----------	----------
Portage	Louis J. Zupp	----------	----------
Preble	----------	----------	----------
Putnam	W. D. Hickey	present	present
Richland	E. D. Dowds	----------	----------
Ross	O. P. Tatman	----------	present
Sandusky	J. L. Curtin	present	----------
Scioto	D. A. Berndt	present	present
Seneca	Paul Leahy	----------	present
Shelby	H. E. Crimm	----------	----------
Stark	John M. Van Dyke	present	present
"	L. E. Anderson	present	present
"	A. R. Basinger	present	present
Summit	R. M. Lemmon	present	present
"	V. C. Malloy	present	present
"	R. E. Pinkerton	present	present
"	C. R. Steinke	present	present
Trumbull	R. D. Herlinger	present	present
Tuscarawas	J. W. Calhoon	present	----------
Union	H. C. Duke	----------	----------
Van Wert	G. A. Edwards	present	----------
Vinton	H. D. Chamberlain	present	present
Warren	Robt. M. Blair	----------	----------
Washington	S. E. Edwards	present	----------
Wayne	R. C. Paul	----------	present
Williams	H. W. Wertz	present	present
Wood	E. A. Powell	----------	----------
Wyandot	C. W. Montgomery	----------	----------
	OFFICERS		
President	C. C. Sherburne	present	present
President-Elect	L. Howard Schriver	present	present
Past-President	E. J. McCormick	present	present
Treasurer	Harry E. LeFever	present	present
	COUNCILORS		
First District	E. O. Swartz	present	present
Second District	H. C. Messenger	present	present
Third District	Guy E. Noble	present	present
Fourth District	A. A. Brindley	present	present
Fifth District	Edgar P. McNamee	present	present
Sixth District	Ralph L. Rutledge	present	present
Seventh District	Carl A. Lincke	present	present
Eighth District	George F. Swan	present	present
Ninth District	Gilbert Micklethwaite	----------	----------
Tenth District	George T. Harding	present	present
Eleventh District	Ross M. Knoble	present	present
TOTALS		99	90

Tallman Named Commissioner of Mental Diseases for Ohio

Announcement was made on May 26 by State Welfare Director Herbert Mooney of the appointment of Dr. Frank F. Tallman, Lansing, Michigan, as Commissioner of Mental Diseases for the State of Ohio, a position which has been vacant for the past several years.



DR. TALLMAN

Ohio physicians will remember that Dr. Tallman was one of the guest speakers at the series of Industrial Health Conferences held in Ohio last February under the joint sponsorship of the Ohio State Medical Association and the Ohio Department of Health. He spoke on "Absenteeism and the Doctor".

Dr. Tallman has been director of mental hygiene, Michigan State Hospital Commission. He is a graduate of the University of Alberta Faculty of Medicine, 1927; a diplomate of the American Board of Psychiatry and Neurosurgery; fellow of the American Medical Association; member of the American Psychiatric Association and the American Orthopsychiatric Association.

Prior to becoming director of the Michigan State Hospital Commission, Dr. Tallman was assistant psychiatrist, Vanderbilt Clinic, New York City, and director of clinical psychiatry, Rockland State Hospital, N. Y.

Dr. Tallman is a native of Red Deer, Alberta, Canada, but is a naturalized citizen of the United States. He is married and has three children.

Every Physician in the Armed Forces Should Vote; How Those in Service from Ohio Can Get November Election Ballot Is Described

EVERY Ohio physician serving with the armed forces, at home or abroad, should consider it his duty to vote in the November election.

Under the provisions of a bill passed by the Ohio General Assembly in special session April 27, absentee voting by persons in the service is greatly facilitated. The procedure is simple.

A physician, who is a legal resident of Ohio, may make written application for an absentee ballot to his county board of elections, or a relative may make the application.

Under the law, applications may be made by "the spouse, father, mother, grandparent, father-in-law, mother-in-law, brother or sister of the whole blood or half blood, son, daughter, adopting parent, adopted child, step-parent, step-child, uncle, aunt, nephew or niece" of the voter.

The application need not be in any particular form. It should merely request an absentee ballot; state the branch of the service in which the applicant is serving, and specify the location of his legal residence in Ohio so that the clerk of the county board of elections can determine the precinct in which he is located.

Applications for "war ballots" can be made now. The ballots will be ready for mailing by the clerk of each county board of elections to the absentee voter on or after August 9. In order to be counted, such ballots must be received by the board by 12:00 noon on election day, November 7.

The Ohio law provides that the absentee voter in the service will have an opportunity to vote for national, state and local candidates. The Federal absentee voting law recently passed by the Congress permits the voter to write-in his choice only for Federal offices. It is not legal in Ohio, and therefore any votes cast under the Federal law will not be counted in Ohio.

Never has there been an election in this country of such vital importance to physicians, not only as citizens but as doctors. Issues are at stake which will affect the future course of their lives and those of their families. Ohio physicians with the armed forces can and should express their views through the ballot by using this simple method of absentee voting.

Ballots will be sent to applicants via air mail, so there will be ample time for them to be marked and returned by election day, November 7, if requested promptly.

News For Expectant Parents

The U. S. Census Bureau recently announced, for the benefit of expectant parents, that the chances are slightly better than 50-50 that "it will be a boy". During 1942, the bureau found, 1,444,365 boys and 1,364,631 girls were born, a ratio of 10,584 boys to every 10,000 girls. While acknowledging that the war might be a factor in some unexplained way, the bureau added that an increase in the boy-to-girl ratio is not exclusively a wartime factor in the United States. For instance, the number of boys born to every 10,000 girls was 10,604 in 1925; 10,588 in 1921 and 10,585 in 1927—each higher than the 1942 ratio.

Tri-State Elects Officers

New officers of the Tri-State Medical Association, elected at the 71st annual meeting, April 11, in Toledo, are: Dr. F. R. N. Carter, South Bend, Ind., president; Dr. F. F. Younkman, Detroit, Mich., vice-president; Dr. John L. Stifel, Toledo, secretary; Dr. D. F. Cameron, Ft. Wayne, Ind., treasurer, and the following councilors: Dr. O. P. Klotz, Findlay; Dr. E. B. Gillette, Toledo; Dr. W. H. Marshall, Flint, Mich.; Dr. H. H. Cummings, Ann Arbor, Mich.; Dr. G. O. Larson, La Porte, Ind., and Dr. H. F. Mitchell, South Bend, Ind.

Annual Address of the President

By C. C. SHERBURNE, M.D., Columbus, Ohio

MEMBERS of the House of Delegates: In calling this, the 98th Annual Meeting of the Ohio State Medical Association, to order, I deem it a duty to come before you with some observations which I have made during the past year while serving you as President.



C. C. SHERBURNE, M.D.

First, may I say that I have appreciated the honor of having had your confidence.

Secondly, I have been more than pleased at the loyalty and cooperation displayed by so many members in Assotion activities, under trying conditions.

It has been an education, as well as a pleasure to work for the Ohio Medical Association. The opportunity which has been afforded me to observe at first-hand the many problems which confront our organization from time to time gives one a sense of humility. Moreover, one finds that the answers to some of these problems are not as easy to find as would be imagined at first glance.

ANNUAL REPORTS SHOULD BE READ

At times such as this, it usually is the habit for the speaker to point with pride or to view with alarm, or do both. Our accomplishments over the past year have not been epochal. However, the usual progress has been made as is so often the case where sustained programs and activities extend over a period of more than one—perhaps several years.

It is not my intention to review the annual reports of the various committees. I would advise that all of you read them as published in the April issue of *The Ohio State Medical Journal*, if you have not done so. May I call to your attention particularly, the report of the Committee on Public Relations and Economics. It contains material with which every member should be conversant. All of the reports should be studied, however, as they present a record of the Association's activities during the past year.

CALM, STUDIOUS ACTION IMPERATIVE

Uncertain and troublesome times are ahead, as you well know. I know that all of you join with me in hoping that peace will come within the next year. But, we must realize that whenever hostilities cease, vexing and unforeseen questions of vital importance to the medical profession will arise during the period of readjustment—many involving the returning servicemen, including our brother physicians.

We can not anticipate what some of these developments will be. But, when new and complicated questions do arise, let us not be hysterical and haphazard in our efforts to meet them. Only through calm deliberations and wise action can we hope to arrive at the right decision.

WE MUST BE LOGICAL AND CONSISTENT

When everyone is overworked, fatigued and harassed, in some instances because of the foolish demands that are made on the physician's time, there is a tendency for us to become impatient and to put too much passion and personal feeling into our arguments and debates. There must be an open exchange of ideas and beliefs. However, let us not forget that we must be logical and consistent. If we are not, we weaken our own cause which is to try to do those things which we believe will be best for all the people and the medical profession generally.

Let us look at our own organization. The Ohio State Medical Association does not represent any particular group within the medical profession of Ohio. It is a democratic organization representing all of its members and the profession-at-large. Each member has an equal right to its services and benefits and an equal voice in its affairs.

This being the case, within our local, state and national organizations is the place for members to voice their views so the majority may judge and decide what is right; what is wrong; what should be done; what should not be done.

BEWARE OF LOOSE TALK

Unfortunately, there is a tendency at times to let loose talk which we hear around the coffee room of a hospital or in the corner drug store to color our thinking and to govern our actions. During many of these "debates", critical analysis is not made. Many statements made on such occasions sooner or later fall of their own weight but not until damage has been done. The effect is to create suspicion and distrust. The end-result is that many times the medical profession of a community becomes disunited which is the very thing we must guard against if we are to succeed in our fight to preserve the practice of medicine as a free enterprise.

Annual Address of the President, delivered at the first session of the House of Delegates, Ohio State Medical Association, at the Ninety-Eighth Annual Meeting, Columbus, Ohio, May 2, 1944.

As we fight to preserve that which we believe is right and against that which we believe will be detrimental to the best interests of the people, let us maintain the traditional dignity of the medical profession. Obviously, we must act as a unit and we must forget the old slogan "too proud to fight". But, in applying the tactics of mass action let us not be led astray by those who feel that we should resort to threats and coercion, restraint of freedom to think and act, even strikes to accomplish our purposes.

DIGNIFIED ACTION ESSENTIAL

Should we adopt such tactics, we would find ourselves endorsing the very things which throttle democracy and freedom of thought and action—a principle which we are hoping will be preserved and which we are defending. The physician as an individual has a right to think for himself and to act as his judgment and conscience dictate so long as his actions are not inimical to public interest. Unity of thought and purpose is highly desirable but we will gain nothing by using strong-arm methods.

In the end, many of the questions of vital concern to us will be settled in the court of public opinion. If we are logical in our arguments to the extent that we can show the public that it will be the loser if our advice and suggestions are ignored, we have nothing to fear. Our good intentions with respect to building up sound public relations and favorable public opinion can be ruined if we lose our heads, our dignity, our sense of balance and our self-respect by yielding to mass psychology.

ONE UNITED ORGANIZATION NEEDED

Speaking of unity of action and public relations, considerable discussion has taken place recently regarding our parent organization—the American Medical Association. Some have labeled it too reactionary. Others have demanded that some of its administrative employes be replaced. Still others have gone so far as to promote the organization of new and separate groups to carry on activities which it is alleged the A.M.A. is not doing or can not do. Let us for a minute analyze this situation.

The American Medical Association represents every physician in the United States. It is the only organization organized for the benefit of specialists and general practitioners alike. It is recognized as the spokesman for the entire medical profession. It is your organization and the Ohio State Medical Association, which also is your organization, is one of its strongest component parts.

NEW GROUPS UNNECESSARY

This being the case, I for one feel that it would be wise for all of us to use our energy to see that the American Medical Association continues as the most powerful medical organization; to correct whatever weaknesses it may have; to improve its operations. By the same token, I believe that it is foolish for us to dilute our strength and scatter our allegiance by forming new organizations, designed for some special function and engaged in collecting funds for this or that special activity. In the final analysis, every activity which these special groups are carrying on is already being carried on by the A.M.A.—or could be if the membership demands. To divide ourself into different groups is not the way to obtain unity of action. By doing so we lose ground as the public eventually will begin to wonder just what organization does represent the medical profession.

HOW METHODS CAN BE CORRECTED

Occasionally, members complain that the A.M.A. does not do things to suit them or does not do things which they feel it should be doing. Those particular members may be wrong—dead wrong. But, for the sake of argument, let us assume that they are right and that the majority of the members of the A.M.A. are in agreement. What are they going to do about it?

The machinery for accomplishing the will of the majority exists within medical organization if the members will but make use of it. Action must start at the county society level. If the majority of the members of a county society want a new policy adopted or a new program inaugurated, they should instruct their delegate, or delegates, to the Ohio State Medical Association accordingly. If the majority of the members of the House of Delegates of the State Association concur, they should instruct the Ohio delegates to the American Medical Association accordingly. If the majority of the members of the A.M.A. House of Delegates take favorable action, their action becomes a mandate to the trustees and administrative staff of the A.M.A. In this manner, opportunity is offered for debate and deliberations and the final result obtained through the use of democratic principles.

MAJORITY WILL EVENTUALLY WIN

Some will say "It won't do any good". I disagree. It will do some good if the members want what they want badly enough and will fight to get it. True, the fight may not be won in the first round. It may take time and organized activity to gain the final favorable verdict. But, eventually the majority will certainly win.

For example, the Ohio resolution asking for the opening of a Washington office did not receive a favorable vote in the A.M.A. House of Delegates last June. Nevertheless, largely because of the debate which took place and as a result of actions taken by the various state medical societies since that time, the A.M.A. Board of Trustees has decided that the majority of the

members want a Washington office and a Washington office has been opened by the A.M.A. If you have an idea, bring it into the open so it can be debated. Even if the majority rule against you, you have accomplished something as you have at least given the membership a chance to voice its opinion one way or another.

PROGRESS VS. CHANGE

Permit me to warn, however, that we should not confuse the terms "progress" and "change". Change is not necessarily progress. Often change takes place through hasty action, unaccompanied by mature judgment. Progress usually is brought about through evolution, based on studious action.

Please do not charge me with being a scolder or a preacher. The only reason I have mentioned these things is because I feel that we can not be adequately prepared to meet the vital questions which will confront us after the war unless we are united and I feel that we can not be united unless we forget petty differences, quit making tempests out of teapots and decide to settle our internal disputes in a democratic fashion. Instead of looking only at the things which medical organization is not accomplishing, let us analyze the many beneficial things which it is accomplishing and has been accomplishing for so many years.

Instead of complaining or bickering, let us devote our time and energy to improving our organization—local, state and national—which can be no stronger than the membership is willing to make it. We have almost 100 years of background and tradition in Ohio. This has been builded through sacrifice and hard work, loyalty and devotion. It can endure indefinitely if we and future generations of physicians will only be as responsive and responsible as those who shared its benefits and governed its affairs in the past.

TRIBUTE TO SERVICEMEN

In closing, may I pay tribute to the almost 3,000 Ohio physicians who are with our fighting forces and scattered throughout the world. These men have made great sacrifices. Many of them are at present on the field of battle. Others will soon be on their way to combat zones. Some have already made the supreme sacrifice. We owe them an eternal vote of appreciation and confidence. In my opinion, the greatest token of appreciation we could extend to our men in the armed forces would be to do everything possible to preserve for them the freedoms and liberties which they enjoyed at the time of their departure and to insure that they will not be forced to return to a regimented social order at the end of hostilities.

Also, may I pay tribute to those physicians on the home front who have carried on so magnificently in meeting the health and medical needs of the civilian population. They too have made sacrifices and have devotedly endeavored to meet their responsibilities. The medical profession again has produced a war record, second to none, and has demonstrated that a free, unregimented profession is capable of meeting its obligations, both to the military and to the civilian population.

COMMITTEE MEMBERS THANKED

Those who have unselfishly given their precious time and energy, while so many of their colleagues have been away, in serving on committees of the State Association and their local societies are entitled to a vote of sincere appreciation. I want them to know that their services have been deeply appreciated and that the entire profession has profited through their work and interest.

I ask you to give my successor, Dr. Schriver, the same collaboration and support which you have given me during the past year. He and his associates on The Council will need your cooperation and assistance as the problems which confront us will multiply in number and in importance. Help him to make the ensuing year the best in the long history of the Ohio State Medical Association.

Congress of Physical Therapy

The American Congress of Physical Therapy, of which Dr. Walter J. Zeiter, Cleveland, is executive director, will hold its twenty-third annual scientific session, September 6, 7, 8 and 9, inclusive, at the Hotel Statler, Cleveland. The annual instruction course will be held from 8:00 to 10:30 A.M., and from 1:00 to 2:00 P.M. during the days of September 6, 7 and 8. The scientific and clinical sessions will be given on the remaining portions of these days and evenings. All sessions will be open to the members of the regular medical profession and their qualified aides. For detailed information address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago 2, Ill.

The Council on Medical Education and Hospitals of the American Medical Association has announced the appointment of Dr. Fritjof H. Arestad to the position of assistant secretary. Dr. Arestad, who has been on the Council staff for 13 years, will be concerned mainly with all hospital activities of the Council including the registry of hospitals, formerly under the direction of Mr. Homer F. Sanger, as well as with internships, residencies and fellowships.

Fred K. Hoehler, former director of public safety in Cincinnati, has been named director of the Division of Displaced Persons in the United Nations' Relief and Rehabilitation Administration.

THE PRESIDENT-ELECT

TO pilot the activities of the Ohio State Medical Association during the crucial period, 1945-46, when it is hoped that peace will have arrived or will be just around the corner, the House of Delegates at the Ninety-Eighth Annual Meeting in Columbus, May 2-4, 1944, selected Dr. Edgar P. McNamee of Cleveland.

By electing Dr. McNamee to the office of President-Elect, the House of Delegates chose for this high office, a physician who ranks high in his specialty—roentgenology—; one who has had many years of experience in medical organization; and a man who on numerous occasions has demonstrated that he can and will fight to the finish to protect the traditions and ideals of the medical profession, to further the activities of medical organization, and to maintain medicine as a free enterprise.



EDGAR P. McNAMEE, M.D.

Born June 29, 1890 in Butler, Pennsylvania, where he received his elementary and high school education, Dr. McNamee entered the University of Pennsylvania for his premedical and medical training, graduating with his M.D. degree in 1913. While in school he affiliated with Alpha Kappa Kappa. Following an internship at Presbyterian Hospital, Philadelphia, he entered general practice in Cleveland.

Entering the military service in 1917 as a First Lieutenant, Medical Corps, U.S.A., Dr. McNamee was assigned to the Pittsburgh School of Roentgenology. Following his training, he was assigned to the Army X-Ray Department. In that capacity he served overseas from March, 1918, to June, 1919. Returning to Cleveland in 1919, he re-opened his office for the practice of roentgenology.

A member of the Cleveland Academy of Medicine, the Ohio State Medical Association and the American Medical Association since 1915, Dr. McNamee has held important offices in the local and state societies. From 1938 to 1941, he was a director of the Cleveland Academy. In 1938 he was elected a member of The Council of the State Association, representing the Fifth District. This year he completed his third consecutive two-year term on The Council, retiring automatically as Councilor under the Constitutional provision limiting Councilors to three consecutive terms. Dr. McNamee is a trustee of the Cleveland Medical Library Association and its director of membership.

Dr. McNamee also has taken a prominent part in the organizational and educational activities of his specialty. He is a past-president and past-secretary of the Cleveland Radiological Society. At present he is First Vice-President of the Radiological Society of North America; member of the Ohio State Radiological Society, and American Roentgen Ray Society; Fellow of the American College of Radiology, American College of Physicians, and American Medical Association; and Diplomate of the American Board of Radiology. As roentgenologist, Dr. McNamee serves on the staffs of three Cleveland hospitals—City, St. Alexis and St. John's.

Golf is Dr. McNamee's favorite sport and hobby, but when he and Mrs. McNamee are not at their residence at 1301 Bunts Road, Lakewood, the chances are good that they are pursuing their favorite form of recreation—travel.

Proceedings of The Council

Important Questions Considered at Sessions Held at Time of Annual Meeting; Special Committees Appointed

MINUTES OF FIRST SESSION

A REGULAR meeting of The Council of the Ohio State Medical Association was held on the afternoon of May 2, 1944, in the Coral Room, Neil House, immediately prior to the opening of the 98th Annual Meeting of the Ohio State Medical Association. All Officers and Councilors, with the exception of Dr. Gilbert Micklethwaite, were present.

In opening the meeting President Sherburne expressed appreciation and thanks to members of The Council for their cooperation and assistance during the past year.

On **motion** by Dr. Noble, seconded by Dr. Knoble, and **carried**, the minutes of the last meeting of The Council held on March 12, 1944, were **approved.**

Membership statistics were reported as follows: Total membership as of May 2, 1944—6,570, of which 1,817 were military members; compared to a total membership of 6,780 on December 31, 1943, of which 1,771 were military members.

A report on final plans for the Annual Meeting program and arrangements was made by the Executive Secretary.

MEDICAL AND HEALTH SERVICES FOR TRANSIENT FARM LABORERS

A communication from the Agricultural Extension Department, Ohio State University, asking for the assistance and cooperation of the Ohio State Medical Association in working out a program to provide medical and health services for transient farm laborers unable to provide such services for themselves, was read and discussed. On **motion** by Dr. Schriver, seconded by Dr. Swartz, and **carried**, the draft of a suggested program was **approved** as a guide to county medical societies. **(See pages 567-8 this issue for complete text of statement of policy and program.)**

YOUNGER PHYSICIANS AND MEMBERSHIP

Following an extensive discussion of the question of encouraging younger physicians, especially those in military service, to affiliate with medical organization, The Council, on **motion** by Dr. Brindley, seconded by Dr. Schriver, and **carried**, adopted the following recommendations for the guidance of the State Headquarters Office and all county medical societies:

A review of the military roster of Ohio physicians now in active military service reveals that there are several hundred who are not at this time affiliated with the Ohio State Medical Association.

Many of these physicians entered the services immediately following internship or residency and before they had an opportunity to establish themselves in private practice.

In the opinion of The Council, physicians in this category should, if they are qualified and eligible, be given an opportunity to affiliate with medical organization. By doing so they will be entitled to receive the benefits and services of the State Association, including *The Ohio State Medical Journal*, and of the local society with which they affiliate. At the same time, medical organization would be benefiting by having within its ranks those young physicians who will eventually become a vital and active segment of the state and local societies following the war.

The Council recommends that each component medical society immediately consider the question of voting such physicians into membership.

The provisions of each component medical society would apply in each case but in general the prospective member would be eligible for membership if he possesses the following qualifications:

1. If he is a legal resident of the county, i.e., resided in the county prior to entrance into medical school, internship or residency.
2. If he meets the requirements of the local constitution and by-laws regarding citizenship, i.e., some societies require full citizenship; others require the filing of first papers only.
3. If he is licensed to practice medicine and surgery in Ohio.
4. If he holds the degree of doctor of medicine or some foreign degree in medicine regarded by The Council of the Ohio State Medical Association as equivalent thereto.
5. If he is acceptable from the standpoint of character, reputation, etc., to the membership of the local society.

Physicians affiliating while in the armed forces would have no financial obligation so far as the Ohio State Medical Association is concerned as they would be covered by the waiver-of-dues policy applying to members in the various services.

It is recommended that the Headquarters Office, Columbus, as soon as feasible, supply the various component societies with the names of Ohio physicians in the services who are not members at present but who may be prospective members.

SURVEYS BY X-RAY CORPORATIONS

A reply from Dr. H. M. Platter, Secretary of the State Medical Board, in answer to an inquiry submitted to him by The Council following its last meeting as to whether certain corporations engaged in the practice of making chest plates as a part of tuberculosis control programs are engaged in the practice of medicine, was read and discussed. It was the opinion of Dr. Platter, based on data obtained from each of these corporations, that they are not violating Sections 1286 or 1287 of the Ohio Medical Practice Act, namely, they are not practicing medicine.

The Council then discussed the question of

whether the practices of some of these corporations, in having designated physicians interpret the plates and provide individuals with the findings, were in line with good medical procedure. On **motion** by Dr. Noble, seconded by Dr. Lincke, and **carried**, this matter was referred to the Committee on Public Relations and Economics for study and a report to The Council. It was suggested that the committee ask for the advice of the Ohio State Radiological Society on this matter.

EMERGENCY MATERNITY AND INFANT CARE PROGRAM

Revisions in the Ohio Emergency Maternity and Infant Care Program, as described in detail in the May, 1944, issue of *The Ohio State Medical Journal*, involving primarily an increase in fees, were discussed.

A communication sent by President Sherburne to members of Congress asking that the program be converted to a cash allotment plan was brought to the attention of The Council.

Another communication from Dr. H. H. Skinner, Yakima, Washington, regarding a conference of members of State Association Maternal and Child Welfare Committees in Denver and periodically thereafter, was read and discussed. On **motion** by Dr. Brindley, seconded by Dr. Swan, and **carried**, The Council expressed itself as believing that there was no need for such a conference at this time. The members of The Council pointed out that each state society should be responsible for studying such matters and making recommendations to members of Congress from their own states; also that state societies should furnish recommendations and suggestions to the American Medical Association which should represent the medical profession nationally on this and other matters.

FOOD AND GASOLINE RATIONING

Reference was made to an article in the May, 1944, issue of *The Ohio State Medical Journal* regarding the new procedure inaugurated by the O.P.A. on food rationing for health needs. A communication from the Lorain County Medical Society on this matter was read and discussed.

On **motion** by Dr. Swartz, seconded by Dr. Noble, and **carried**, The Council expressed itself as believing that the new procedures adequately meet the criticism of the Lorain County Medical Society. The members of The Council also expressed themselves as believing that the question of gasoline allotments for patients and the requirement for a statement by the attending physician were matters resting entirely within the jurisdiction of local rationing boards. However, The Council instructed the State Headquarters Office to discuss these matters with the proper district officials in event any local board imposed unreasonable requirements on physicians or patients.

A report was made to The Council on a conference held in the State Headquarters Office on Sunday, April 23, for the purpose of informal discussions on medical service plans, such conference having been attended by representatives of interested county medical societies. On **motion** by Dr. Brindley, **seconded** by Dr. Rutledge, and **carried**, a recommendation made by those attending the conference, that The Council authorize the Executive Secretary to send to all county medical society presidents and secretaries and other interested physicians a copy of the proposed Youngstown Plan and a resume of the Toledo Plan, was **approved** with the additional recommendation that data also be obtained from the American Medical Association on plans now in operation in other parts of the country and that similar information be obtained from the National Physicians' Committee for distribution to the various county societies.

MISCELLANEOUS

A communication from the American Social Hygiene Association, asking the Ohio State Medical Association to serve as a sponsor for a meeting of the American Social Hygiene Association to be held in Cleveland, May 25, was read and discussed. On **motion** by Dr. Knoble, seconded by Dr. Brindley, and **carried**, the Executive Secretary was instructed to inform that Association that the Ohio State Medical Association would assist in publicizing the meeting and endeavor to have an official observer present at the scheduled sessions of that Association.

A communication from a county medical society, recommending that The Council adopt a resolution criticizing the present administrative officers of the American Medical Association and asking for the removal of certain of these officers, was filed for future consideration, on **motion** by Dr. Schriver, seconded by Dr. Messenger, and **carried**.

On **motion** by Dr. Lincke, seconded by Dr. McNamee, and **carried**, The Council paid tribute to Dr. Sherburne, the retiring president, for his excellent and conscientious work during the past year, and authorized the Executive Secretary to send flowers, on behalf of The Council, to Mrs. Sherburne and to Mrs. Schriver, wife of Dr. Schriver, the President-Elect.

There being no further business, The Council adjourned to meet with the House of Delegates at 3:30 P.M. on May 2.

Attest: CHARLES S. NELSON,
Executive Secretary

SPECIAL MEETING OF THE COUNCIL

A SPECIAL meeting of The Council was held on the afternoon of May 4, 1944, immediately following the final session of the House of Delegates.

Dr. Schriver, the newly installed President, made the following appointments to special com-

mittees, which appointments were **confirmed** by The Council on **motion** by Dr. Knoble, seconded by Dr. Swan, and **carried:**

Auditing and Appropriations—Dr. Ralph L. Rutledge, Alliance, chairman; Dr. Carl A. Lincke, Carrollton, and Dr. George T. Harding, Columbus.

Woman's Auxiliary Advisory Committee—Dr. A. A. Brindley, Toledo, chairman; Dr. George T. Harding, Columbus, and Dr. Fred W. Dixon, Cleveland.

Sub-Committee on Legislation—Dr. Ralph M. Watkins, Cleveland, chairman; Dr. Emil R. Swepston, Cincinnati; Dr. G. A. Woodhouse, Pleasant Hill; Dr. Floyd M. Elliot, Ada; Dr. D. J. Slosser, Defiance; Dr. John M. Van Dyke, Canton; Dr. Jay W. Calhoon, Uhrichsville; Dr. R. G. Plummer, Newark; Dr. Clyde M. Fitch, Portsmouth; Dr. Wayne Brehm, Columbus; Dr. Geo. F. Linn, Norwalk.

Committee on Industrial Health—Dr. Barney J. Hein, Toledo, chairman; Dr. J. Craig Bowman, Upper Sandusky; Dr. D. W. Heusinkveld, Cincinnati; Dr. H. M. Platter, Columbus; Dr. Cecil Striker, Cincinnati; Dr. George F. Sykes, Cleveland; Dr. O. J. Walker, Youngstown; Dr. Ralph M. Watkins, Cleveland; Dr. Carl A. Wilzbach, Cincinnati; Dr. Clyde W. Dawson, Columbus; Dr. F. G. Barr, Dayton; the President, the President-Elect, and the Past-President, Ex Officio.

Sub-Committee on Workmen's Compensation—Dr. Barney J. Hein, Toledo, chairman; Dr. C. W. Dawson, Columbus; Dr. J. Craig Bowman, Upper Sandusky; Dr. D. W. Heusinkveld, Cincinnati; Dr. E. R. Bader, Cincinnati; Dr. James R. Driver, Cleveland; Dr. B. B. Sankey, Cleveland; Dr. L. N. Jentgen, Columbus; Dr. M. Paul Motto, Cleveland; Dr. John M. Van Dyke, Canton.

Sub-Committee on Public Health Education—Dr. Carl A. Wilzbach, Cincinnati, chairman; Dr. F. L. Shively, Dayton; Dr. Edward King, Cincinnati; Dr. C. E. Hufford, Toledo; Dr. L. A. Pomeroy, Cleveland; Dr. Myron Miller, Columbus; Dr. Jonathan Forman, Columbus; Dr. John S. Hattery, Mansfield; Dr. Frank M. Hartsook, Cardington; Dr. Hazelett A. Moore, Oxford.

Committee on War Participation—Dr. Robert Conard, Wilmington, chairman; First District—Dr. Chas. E. Hauser, Cincinnati; Second District—Dr. Merrill D. Prugh, Dayton; Third District—Dr. Frank M. Wiseley, Findlay; Fourth District—Dr. Dale Wilson, Toledo; Fifth District—Dr. James N. Wychgel, Cleveland; Sixth District—Dr. Charles A. LaMont, Canton; Seventh District—Dr. Carl A. Lincke, Carrollton; Eighth District—Dr. Blaine R. Goldsberry, Athens; Ninth District—Dr. Harry F. Rapp, Portsmouth; Tenth District—Dr. John H. Mitchell, Columbus; Eleventh District—Dr. Charles R. Keller, Mansfield.

Committee on Medical Service Plans—Dr. Robert C. Rothenberg, Cincinnati, chairman; Dr. Wm. M. Skipp, Youngstown; Dr. Jonathan Forman, Columbus; Dr. R. K. Finley, Dayton; Dr. Robert E. S. Young, Columbus; Dr. Carll S. Mundy, Toledo; Dr. Reyburn McClellan, Xenia; and the following ex officio members, Mr. Stanley R. Mauck, Columbus, executive secretary of the Columbus Academy of Medicine; Mr. George W. Cooley, Toledo, executive secretary of the Toledo Academy of Medicine; and Mr. J. L. Price, Youngstown, Medical-Dental Bureau.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary

Dr. Fred W. Dixon, Cleveland, New Member of The Council

A newcomer on The Council of the Ohio State Medical Association is Dr. Fred W. Dixon, Cleveland. He was elected by the House of Delegates at the recent Ninety-Eighth Annual Meeting as Councilor of the Fifth District for a two-year term, succeeding Dr. Edgar P. McNamee, Cleveland, who was named President-Elect.



DR. DIXON

Dr. Dixon was born in Lawrence County, Pennsylvania, in 1888. After graduating from Geneva College in 1912, he entered the University of Pennsylvania Medical School where he received his M.D. degree in 1917.

After serving a year in the Medical Corps, Army of the United States, during World War I, Dr. Dixon located in Leetonia where he engaged in general practice for four years before engaging in postgraduate work in otolaryngology at the New York Eye and Ear Infirmary and in Vienna. In 1925, he moved to Cleveland where he has limited his practice to his specialty.

At present, Dr. Dixon is on the visiting staff at St. Alexis and Lakeside hospitals and is assistant clinical professor of otolaryngology at Western Reserve University School of Medicine.

For the past five years Dr. Dixon has served as a member of the Committee on Scientific Work of the Ohio State Medical Association, his term having expired this year.

In addition to being a Fellow of the American Medical Association, Dr. Dixon is affiliated with the following organizations: American Academy of Otolaryngology, American Broncho-esophagological Society, American Laryngological Society, and the American Laryngological, Rhinological and Otological Society.

Plans To Provide Health Services and Medical Care For Transient Farm Workers in Ohio Formulated by The Council; Cooperation of County Societies Asked

BETWEEN 50,000 and 65,000 specially recruited farm workers will be employed in agricultural pursuits in Ohio during the Summer months in an effort to solve one of the most vital problems which has arisen because of the war, namely, a shortage of farm labor. Many of these workers will be on the job by the time this issue of *The Journal* reaches members of the Ohio State Medical Association.

The Agricultural Extension Service, Ohio State University, has the responsibility for recruiting farm workers within Ohio and for seeing that they receive necessities if unable to provide them for themselves. The Office of Labor, War Food Administration, has the same responsibilities with respect to farm workers recruited from other states or countries and imported to Ohio for agricultural work. It is estimated that the greatest number of the workers recruited will be residents of Ohio—intra-state workers—rather than residents of other states or countries. Federal funds have been appropriated to finance this farm labor program. Administration of that phase of the program relating to workers who are residents of Ohio will be handled by the Extension Department, Ohio State University.

The Agricultural Extension Department, Ohio State University, recently requested the Ohio State Medical Association to assist in the formation of a program which will provide necessary health and medical services for these recruited farm workers. Many such workers, no doubt, will be able to provide necessary medical care from their earnings; some may have to look to the Extension Service for financial assistance.

The Council of the State Medical Association considered this request at its meeting on May 2, 1944, and after studying the question offered its cooperation and assistance. A statement containing basic policies and recommendations was adopted by The Council, which statement places local responsibility in the hands of each County Medical Society and offers several alternative plans as the basis for any local program.

Following are the text of the statement of policy adopted by The Council and the text of a communication sent by the Executive Secretary under date of May 8, pursuant to the instructions of The Council, to the President and Secretary of each County Medical Society, requesting cooperation on the part of each society and all members of the medical profession:

POLICY OF OHIO STATE MEDICAL ASSOCIATION ON MEDICAL AND HEALTH SERVICES FOR TRANSIENT FARM LABORERS, ADOPTED BY THE COUNCIL OF THE ASSOCIATION, MAY 2, 1944

The Council of the Ohio State Medical Association has considered a request from the Agricultural Extension Service, Ohio State University, for advice and assistance in the formation of a program which will provide necessary health and medical services for workers who will be recruited within Ohio and employed for agricultural purposes in this state during 1944.

One of the vital problems which has arisen as a result of the war is that of providing a sufficient number of workers for agricultural purposes in this and other states.

Under the provisions of Public Law No. 229, passed by the Congress and effective February 14, 1944, the Extension Service of each Land-Grant College is delegated the responsibility for recruiting, transporting, placing, training and supervising workers for this emergency and, when necessary, for providing them with subsistence, shelter, protection and health, medical and burial services. Federal funds for carrying out this program have been appropriated for allocation to the Extension Services of the various states.

The Agricultural Extension Service, Ohio State University, estimates that between 50,000 and 65,000 Ohio workers will be recruited and placed for agricultural purposes in Ohio during this year.

The Council of the Ohio State Medical Association, after considering the request for assistance, offers its cooperation and submits the following basic recommendations as to policy and procedure:

1. Any program established should be regarded as an emergency project in effect only for the duration of the present emergency.
2. Federal funds made available under the provisions of Public Law 229 shall be expended for health and medical service only when the farm worker is unable to provide such services for himself and his family.
3. As needs and conditions will vary in different counties, the program for a given county should be adapted to local situations and should be worked out mutually by the County Extension Agent or some other duly appointed representative of the Agricultural Extension Service, Ohio State University; representatives of the County Medical Society; the health commissioner having jurisdiction and official representatives of other groups expected to supply necessary services.
4. In event Federal funds are used, fees and compensation paid for services rendered to eligible farm workers should be comparable to the usual charges prevailing in the community for similar services rendered to persons of like standard of living.
5. Only local personnel and facilities shall be utilized in implementing local health and medical programs unless such local personnel and facilities are inadequate to provide necessary services.

The following supplemental recommendations are submitted as the basis for determining the

responsibilities and activities of local groups expected to provide health and medical services:

1. The County Extension Agent shall be responsible for administrative and clerical details, including the handling and endorsement of fee bills and statements submitted by those rendering services.

2. The health commissioner having jurisdiction shall be responsible for providing a public health and sanitary program to adequately protect workers who may be housed at camps, labor supply centers, etc.

3. The local hospital or hospitals, if any, or a hospital in an adjacent area, shall be responsible for providing hospitalization, when necessary, under an agreement with the County Extension Agent.

4. If emergency dental services and emergency nursing services are needed, arrangements for such services should be worked out through conferences with representatives of the state organizations of the dental and nursing professions.

5. The County Medical Society shall be responsible for seeing that necessary medical services are available. This may be accomplished by adoption of any one or a combination of the following methods:

(a) Participation in the program by all physicians of the county on a free-choice, fee-for-service basis;

(b) Participation in the program of certain physicians, volunteering their services on a rotating fee-for-service basis;

(c) Designation by the County Medical Society of one or several physicians willing to assume full responsibility for providing necessary services for farm workers covered by the program, compensation to be on a fee-for-service basis or on a flat-fee basis at the discretion of the physicians so designated.

It is understood that approximately 1,000 workers who are residents of other states or countries will be imported into Ohio during 1944 as agricultural workers. These inter-state workers are under the supervision of the Office of Labor, War Food Administration. The Council of the Ohio State Medical Association recommends that the foregoing provisions and suggestions also be used as the basis for health and medical programs for the protection of such classes of workers.

TEXT OF BULLETIN TO OFFICERS OF COUNTY MEDICAL SOCIETIES

To: Presidents and Secretaries,
County Medical Societies

MEDICAL AND HEALTH SERVICES FOR FARM LABORERS

Your attention is called to the attached Statement of Policy of the Ohio State Medical Association on Medical and Health Services for Transient Farm Laborers, adopted by The Council of the State Medical Association on May 2, 1944.

The Council urges all County Medical Societies to cooperate with official representatives responsible for the needs of farm laborers recruited for farm work in Ohio in line with the basic policies set forth in The Council's statement.

You will note that each County Medical Society is given the right to handle this problem as it sees fit under any one of the alternative plans suggested or a combination of such plans. There is no rigid state-wide plan which all counties must comply with. The statement sets forth only basic principles and offers suggestions for local procedure.

It is our understanding that the Statement of Policy is entirely agreeable to representatives of the Agricultural Extension Service, Ohio State University, who will be in charge of farm workers recruited within Ohio. Most of the workers will be intra-state workers.

A copy of the statement is being transmitted to the Office of Labor, War Food Administration, which will be in charge of workers recruited in other states and countries and brought into Ohio to work on Ohio farms. As the statement points out, The Council feels that any program worked out for intra-state laborers also would be feasible for workers brought in from other states and countries.

These workers will be in Ohio during the Summer. They will need some medical and health services. The Council believes that the general program suggested will provide ample protection for them as well as for the members of the medical profession. The Council hopes that all County Medical Societies will cooperate by meeting immediately on this matter and by working out a plan, as suggested, to take care of this emergency problem.

CHARLES S. NELSON,
Executive Secretary

Class of '97 Holds Reunion

The Class of 1897 of the Ohio Medical University held a reunion at the Neil House, May 3, during the 98th Annual Meeting of the Ohio State Medical Association. Of the 60 graduates in the class, 23 are known to be alive, of whom 15 attended the reunion. This was the first reunion Dr. Edward Reinert, Columbus, failed to attend. His funeral was held on May 3. Many fine testimonials were expressed concerning him by his classmates.

Members of the class of '97 who attended the reunion and talked over "the good old days of 47 years ago", were: Dr. J. S. Cherrington, Logan; Dr. George Gardner, Ashville; Dr. Earl Euans, Magnetic Springs; Dr. I. C. Kiser, Piqua; Dr. Pearl Longbrake, Marysville; Major J. N. Merrick (ret.), Alliance; Dr. W. T. Pyle, Pittsburgh, Pa.; Dr. L. E. Wills, Waverly; Dr. Earl Yates, Piqua; Dr. J. Stanley Hill, Lima; Dr. Herman L. Harris, Dr. John Hutchfield, Dr. B. W. Meyer and Dr. Louis C. Benkert, Columbus. Dr. Benkert is secretary of the class.

Prescriptions by the nation's druggists reached a new high in 1943, according to Dr. E. L. Newcomb, executive vice-president of the National Wholesale Druggists' Association. The total was more than 230,000,000, as compared with a normal total of 200,000,000 per year. Dr. Newcomb interpreted the rise as an indication that the American people are using some of their increased earnings to purchase more adequate medical care.

Total Registration at Columbus Meeting, 1,421; Names Of Members Attending and Miscellaneous Statistics

IN spite of wartime conditions and the fact that almost 2,000 members of the Ohio State Medical Association are in military service, the attendance at the Ninety-Eighth Annual Meeting, May 2, 3 and 4, Columbus, was surprisingly large.

Total registration at sessions of the Association and the Woman's Auxiliary was 1,421, including 830 members of the Association; 20 out-of-state physicians; 441 guests, including 133 medical students; and 130 exhibitors.

Following are registration figures for Annual Meetings held from 1919 to 1944, inclusive; registration by counties for the 1944 Annual Meeting and membership data; and the names of members of the Ohio State Medical Association who registered at the 1944 meeting:

Annual Meeting Registration For 1919-1944, Inclusive

Year	Place	Members	Out-of-State Physicians	Guests	Technical Exhibitors	Total
1919	Columbus	1173	10	264	92	1529
1920	Toledo	810	17	105	80	1062
1921	Columbus	1275	28	204	96	1503
1922	Cincinnati	1066	21	184	70	1341
1923	Dayton	1117	19	202	76	1414
1924	Cleveland	1301	13	180	109	1603
1925	Columbus	1204	17	361	107	1689
1926	Toledo	903	19	120	83	1125
1927	Columbus	1320	17	286	82	1705
1928	Cincinnati	916	27	92	80	1116
1929	Cleveland	1231	15	249	124	1619
1930	Columbus	1241	13	435	86	1775
1931	Toledo	826	13	198	50	1087
1932	Dayton	978	2	201	45	1226
1933	Akron	858	6	160	25	1049
1934	Columbus	1069	9	410	51	1539
1935	Cincinnati	973	17	197	84	1271
1936	Cleveland	1099	14	563	137	1813
1937	Dayton	1103	18	366	64	1551
1938	Columbus	1330	15	619	104	2068
1939	Toledo	1056	15	271	84	1426
1940	Cincinnati	1126	26	323	114	1589
1941	Cleveland—Joint Meeting with A.M.A.					
1942	Columbus	1221	13	527	119	1880
1943	Columbus	544	13	160	----	717
1944	Columbus	830	20	441	130	1421

Registration, 1944 Annual Meeting, By Counties and Membership Data

County	Total Membership Dec. 31, 1943	Total Membership May 1, 1944	Annual Meeting Registration
Adams	17	17	3
Allen	77	73	11
Ashland	24	24	2
Ashtabula	53	50	3
Athens	33	29	8
Auglaize	28	23	5
Belmont	56	54	5
Brown	4	4	----
Butler	93	89	7
Carroll	9	8	2
Champaign	20	21	2
Clark	79	76	10
Clermont	25	26	1
Clinton	19	22	9
Columbiana	60	47	5
Coshocton	24	24	6
Crawford	30	31	8
Cuyahoga	1389	1363	45
Darke	29	25	3
Defiance	15	15	1
Delaware	24	24	9
Erie	41	41	3
Fairfield	41	38	11
Fayette	14	14	4
Franklin	561	554	227
Fulton	21	20	----
Gallia	22	19	1
Geauga	12	12	1
Greene	34	31	5
Guernsey	28	26	4
Hamilton	869	845	58
Hancock	42	60	3
Hardin	21	20	3
Harrison	14	13	2
Henry	16	16	1
Highland	24	23	3
Hocking	13	11	4
Holmes	8	8	3
Huron	29	28	5
Jackson	9	9	1
Jefferson	65	63	2
Knox	30	29	8
Lake	39	34	1
Lawrence	25	20	3
Licking	54	49	15
Logan	25	23	----
Lorain	107	106	6
Lucas	382	372	36
Madison	17	17	5
Mahoning	233	231	17
Marion	47	48	13
Medina	30	30	2
Meigs	13	13	3
Mercer	18	17	2
Miami	49	47	13
Monroe	5	4	1
Montgomery	346	316	34
Morgan	8	8	2
Morrow	8	8	3
Muskingum	52	46	12
Ottawa	19	20	2
Paulding	14	13	1
Perry	18	17	6
Pickaway	13	15	5
Pike	8	8	2
Portage	29	29	----
Preble	13	10	2
Putnam	20	20	3
Richland	82	79	8
Ross	44	43	16
Sandusky	38	37	5
Scioto	67	62	13
Seneca	38	37	7
Shelby	20	21	3
Stark	220	210	25
Summit	321	316	25
Trumbull	80	78	9
Tuscarawas	53	47	7
Union	15	15	9
Van Wert	21	21	2
Vinton	4	4	1
Warren	19	17	2
Washington	31	28	6
Wayne	44	40	2
Williams	19	19	2
Wood	37	37	1
Wyandot	13	13	4
Totals	6780	6570	830

Members of State Association Who Registered at 1944 Meeting

Adams County—R. B. Ellison, S. J. Ellison, Hazel L. Sproull. Allen County—W. H. Beery, M. R. Bixel, E. H. Crawfis, Donald W. English, Walter A. Noble, John E. Talbott, C. E. Savage,

M. D. Soash, H. A. Thomas, J. R. Tillotson, E. C. Yingling.

Ashland County—Robert P. Bogniard, George Riebel. **Ashtabula County**—P. J. Collander, Alfred A. DeCato, Orville J. Lighthizer. **Athens County**—Allen A. Baldwin, Hubert H. Fockler, Beatrice Postle, C. N. Sanders; J. R. Sprague, Edward I. Stanley, J. L. Webb, C. E. Welch.

Auglaize County—R. C. Hunter, Guy E. Noble, Harry S. Noble, Edward P. Sparks, T. H. Will. **Belmont County**—John A. Brown, C. W. Lose, Henry M. Metcalf, Harvey H. Murphy, D. O. Sheppard. **Butler County**—C. T. Atkinson, Fred Brosius, Lee H. Brown, Mildred White Gardiner, Wilmer E. Griffith, Vera Coombs Iber, H. M. Lowell. **Carroll County**—Lewis W. Cellio, Carl A. Lincke. **Champaign County**—D. C. Houser, W. A. Yinger.

Clark County—Arthur R. Cohen, C. W. Evans, D. W. Hogue, G. M. Lane, Jas. H. Riley, Geneva Shong Rothemund, C. W. Schilke, Will Ultes, N. S. Wright, S. C. Yinger. **Clermont County**—F. S. Skeen. **Clinton County**—H. R. Bath, Robert Conard, R. W. DeCrow, J. H. Frame, L. H. Fullerton, Kelley Hale, V. E. Hutchens, C. C. Kinzel, William L. Wead. **Columbiana County**—Lea A. Cobbs, L. F. Derfus, John A. Fraser, R. T. Holzbach, E. C. Louthan.

Coshocton County—Floyd W. Craig, R. E. Hopkins, S. B. Kistler, H. W. Lear, D. S. McDill, J. G. Smailes. **Crawford County**—C. Adams, K. H. Barth, D. D. Bibler, Mart L. Helfrich, O. R. Kackley, C. A. Lingenfelter, R. M. Malone, G. T. Wasson.

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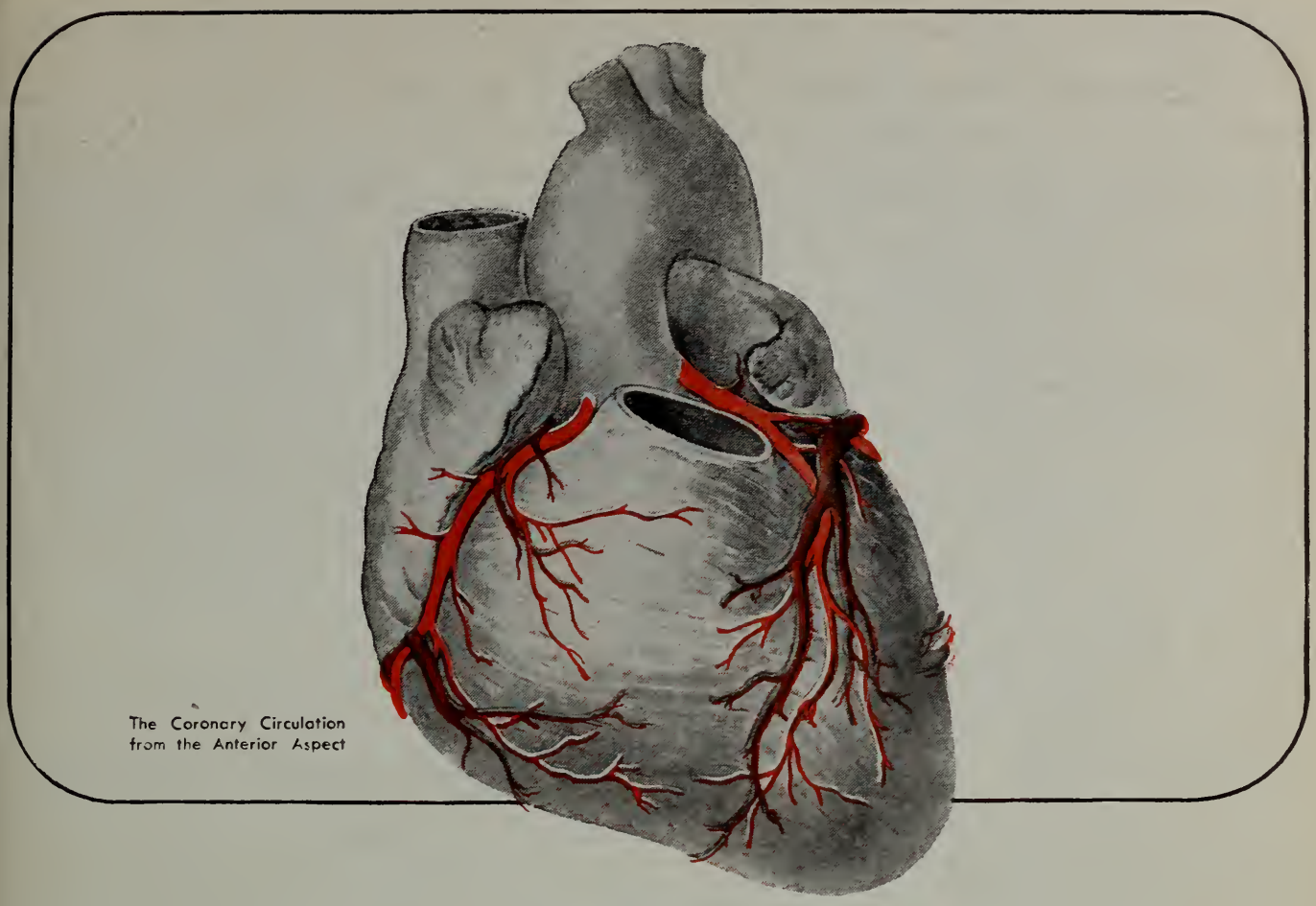
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The National Association for the Care of the Advanced Cancer Patients, Inc., was incorporated recently in New York, with Dr. Frank E. Adair, president of the American Society for the Control of Cancer and chairman of the Cancer Committee of the American College of Surgeons, as medical advisor. The non-sectarian group was created "to provide beds and care in already established institutions, or to finance the establishment of new institutions, if necessary, to provide assistance for advanced cancer patients of moderate means".

The 125th anniversary of the opening of Cincinnati College was celebrated with a dinner at the Netherland Plaza on May 4. Dr. Tom D. Spies was the guest speaker. The college charter was issued by the State Legislature on January 22, 1819, and the first session convened May 4 in that year. The Medical College of Ohio opened the following year.



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RESEARCH IN THE SERVICE OF MEDICINE

Woman's Auxiliary Holds Successful Meeting; Report of Business Transacted; New Officers and Committees

ANOTHER successful annual meeting of the Woman's Auxiliary to the Ohio State Medical Association was held at the Deshler-Wallick Hotel, Columbus, May 2-4, with approximately 100 women in attendance.

Mrs. J. L. Stevens, Mansfield, the President, called the group to order at the opening session of the House of Delegates, Tuesday afternoon, May 2. Dr. Roy A. Burkhart, pastor of the First Community Church, Columbus, gave the invocation. Greetings were extended by Mrs. John Earl Briggs, Columbus, general convention chairman, and Mrs. John W. Wilce, President of the Woman's Auxiliary to the Columbus Academy of Medicine, the response being given by Mrs. Frank Siedenburg, Portsmouth, Vice-President of the State Auxiliary. Mrs. David Thomas, Lockhaven, Pa., President-Elect of the Woman's Auxiliary to the American Medical Association, was a guest at the meeting.

On Tuesday evening there were three "Little Dinners", followed by general discussions. Topics presented and the group leaders were: "Doctors' Wives in the War Effort and Home Community Service", Mrs. R. S. Fidler, Columbus, and Mrs. Dale P. Osborn, Cincinnati; "Medical Legislation", Mrs. D. W. Heusinkveld, Cincinnati, and Mrs. Maurice Hoyt, Hillsboro; "Informing Ourselves That We May Inform Others", Mrs. Murray E. Goodrich, Toledo.

The traditional President's reception for members of the Ohio State Medical Association and their wives was held in the Hall of Mirrors at 10:00 P.M. Tuesday. Various officials of the State Association and the Woman's Auxiliary were in the receiving line.

REPORTS MADE

At the second session of the House of Delegates Wednesday morning, May 3, reports of the officers and chairmen of standing committees were considered and accepted. The Auxiliary now has over 1,200 members in 23 counties. Mrs. Theodore Vinke, Cincinnati, the Treasurer, reported the Auxiliary's checking account balance to be $564.49 as of May 1, with $606.10 in the savings account. The session concluded with an impressive memorial service for departed members, conducted by Mrs. Siedenburg.

Speakers at the Tuesday noon luncheon included: Mrs. Thomas; Miss Bell Greve, executive secretary of the Cleveland Rehabilitation and Relief Association; Dr. C. C. Sherburne, Columbus, President, and Dr. L. Howard Schriver, Cincinnati, President-Elect, of the Ohio State Medical Association.

In the afternoon members of the Auxiliary were guests of the Woman's Auxiliary to the Columbus Academy of Medicine at a tea in the Wallick Suite.

RESOLUTIONS ADOPTED

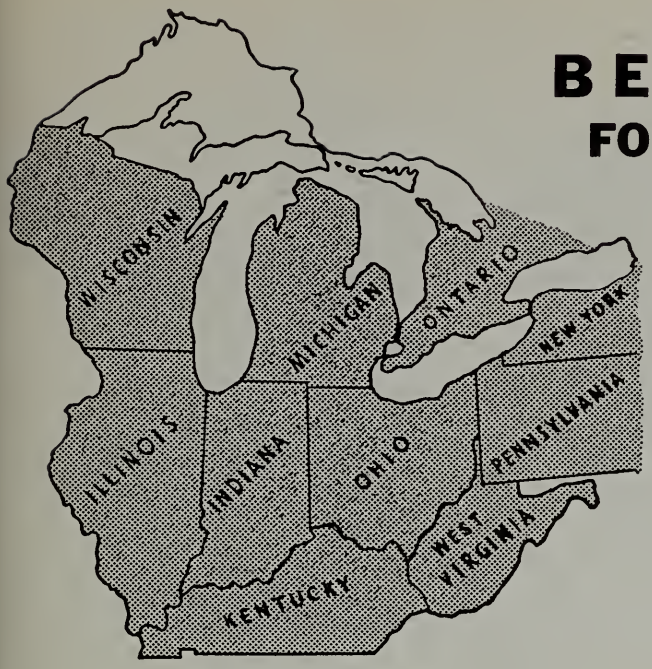
The House of Delegates approved the following recommendations of the Board of Directors at the third session, Wednesday morning, May 3: (1) That one $500 Series "G" Victory Bond be purchased with funds now in the Nurses' Loan Scholarship Fund, the same to be kept available for use for nurses' scholarships when needed; (2) That the new board be instructed to purchase Series "G" Bonds with surplus funds in the checking account after the Treasurer's report at the Fall board meeting shall determine the amount available; (3) That the 1944-45 board be authorized to revise the constitution of the Auxiliary; (4) That the delegates to the June meeting of the A.M.A. Woman's Auxiliary be instructed to vote against a proposed constitutional revision providing for the removal of chairmen of standing committees and state presidents from the national board; (5) That the delegates be instructed to vote against another amendment to the national constitution proposing that nominations come only from the floor instead of being presented by a nominating committee; (6) That wives, mothers and daughters of physicians in the armed forces be informed that they may make application at their local boards of election for absentee voting privileges for servicemen in their families.

A motion was adopted instructing the program committee to furnish material again this year for a medical study program for the local auxiliaries.

NEW OFFICERS AND DIRECTORS

The following new officers were elected for the ensuing year: Mrs. Paul A. Davis, Akron, President-Elect; Mrs. Clyde M. Fitch, Portsmouth, Vice-President; Mrs. David W. Heusinkveld, Cincinnati, Secretary; and Mrs. Dean A. Nesbit, Youngstown, Treasurer. Mrs. R. S. Fidler, Columbus, the incoming president and the other officers, were installed by Mrs. Osborn, the Past-President. A silver bowl was presented to Mrs. Stevens, the retiring President, in appreciation of her valuable services to the Auxiliary.

The following were elected district directors: First, Mrs. W. B. Roads, Hillsboro; Second, Mrs. Kenneth Lowry, Troy; Third, Mrs. Claude Lingenfelter, Bucyrus; Fourth, Mrs. Paul Holmes, Toledo; Fifth, Mrs. John Phillips, Cleveland; Sixth, Mrs. John J. McDonough, Youngstown; Seventh, Mrs. C. J. Miller, New Philadelphia; Eighth, Mrs. R. H. Sloan, Marietta; Ninth, Mrs.



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*A.M.A. Council-Accepted

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W. E. Singleton, Portsmouth; Tenth, Mrs. George E. Cooper, Clarksburg; Eleventh, Mrs. C. H. Bell, Mansfield.

Nominations for delegates to the Woman's Auxiliary to the American Medical Association resulted in the following being elected: Mrs. Davis; Mrs. A. P. Hunt, Portsmouth; Mrs. G. I. Stafford, Oxford; Mrs. Stevens; Mrs. V. C. Malloy, Akron; Mrs. George Wilcoxon, Alliance; Mrs. Robert Bogniard, Ashland; Mrs. Osborn; Mrs. Gerald Castle, Cincinnati; Mrs. Carl Nohe, Akron; Mrs. R. B. Poling, Youngstown; and Mrs. Goodrich. Alternates elected were: Mrs. A. E. Brant, Youngstown; Mrs. R. T. Holzbach, Salem; Mrs. Roy Steingrube, Cincinnati; Mrs. Fitch and Mrs. Siedenburg.

Speakers at the luncheon Thursday noon included: Dr. A. A. Brindley, Toledo, and Dr. George T. Harding, Columbus, members of the Advisory Council to the Woman's Auxiliary; Dr. J. L. Stevens, Mansfield, and Dr. R. S. Fidler, Columbus.

COMMITTEES NAMED

At the post-convention board meeting, Mrs. Fidler appointed the following chairmen of standing committees: Mrs. Stevens, finance; Mrs. Fred M. Brosius, Middletown, publicity; Mrs. H. K. Mouser, Marion, *Hygeia;* Mrs. Ralph W. Hoffman, Columbus, program; Mrs. W. Frank Maxwell, Toledo, legislation; Mrs. Emerson Gillespie, Canton, public relations; Mrs. L. L. Liggett, St. Clairsville, historical; Mrs. Davis, organization. The following are chairmen of special committees; Mrs. Wilcoxon, nurses' loan fund; Mrs. Osborn, revisions to constitution; Mrs. Frank Riebel, Columbus, bulletin and handbook.

The following resolution was adopted:

WHEREAS, The Woman's Auxiliary to the Ohio State Medical Association has been the recipient of excellent cooperation and courtesy, therefore

BE IT RESOLVED, That the Woman's Auxiliary express its sincere appreciation to Mr. Charles Nelson and his staff for their courtesy and cooperation in the past year, and to those who have added so much to the fine spirit of hospitality; to Mrs. J. L. Stevens, President, and the officers and chairmen who have made possible another successful year of our organization; to the Franklin County Auxiliary for its hearty welcome and generous hospitality; to Mrs. John Earl Briggs, convention chairman, and her committee, for their splendid cooperation; to Dr. Roy Burkhart for his thoughtful invocation; to Mrs. David Thomas, President-Elect of the Woman's Auxiliary to the American Medical Association, Miss Bell Greve, Director, Ohio State Rehabilitation and Relief Association, Dr. C. C. Sherburne, President, Ohio State Medical Association and Dr. L. Howard Schriver, President-Elect, for their inspiring addresses; and to the Deshler-Wallick Hotel for the courtesy and hospitality extended to the officers, members and guests of the Auxiliary, particularly difficult in wartime.

At its pre-convention meeting, the board adopted a resolution requesting the Ohio State Medical Association to stimulate activity by county medical societies in a demand for more complete periodic health examinations of school teachers and other school employes.

Names of women who registered at the fourth annual meeting of the Auxiliary follow:

Cincinnati—Mrs. Gerald Castle, Miss Gertrude Heisel, Mrs. David W. Heusinkveld, Mrs. Dale P. Osborn, Mrs. L. Howard Schriver, Mrs. Henry A. Springer, Mrs. C. Roy Steingrube, Mrs. E. O. Swartz, Mrs. Theodore Vinke.

Columbus—Mrs. Charles W. Barch, Mrs. Wayne Brehm, Mrs. J. E. Briggs, Mrs. H. M. Brundage, Mrs. Ivor Clark, Mrs. Geo. Cooperrider, Mrs. R. S. Fidler, Mrs. Floyd Green, Mrs. John Hoberg, Mrs. Ralph Hoffman, Mrs. Geo. O. Hoskins, Mrs. Robert Inglis, Mrs. Henry W. Karrer, Mrs. J. E. Kerschner, Mrs. M. E. Millhon, Mrs. Link Murphy, Mrs. Ernest M. Parrot, Mrs. Charles W. Pavey, Mrs. Frank Riebel, Mrs. John A. Riebel, Mrs. Wynne Silbernagel, Mrs. John W. Wilce, Mrs. G. W. Woods.

Toledo—Mrs. Murray Goodrich, Mrs. Paul Holmes, Mrs. W. Frank Maxwell. **Akron**—Mrs. R. A. Bohl, Mrs. Paul Davis, Mrs. R. A. Gregg, Mrs. V. C. Malloy, Mrs. D. M. McDonald, Mrs. Carl Nohe, Mrs. C. F. Wharton.

Youngstown—Mrs. Hubert S. Banninga, Mrs. C. H. Beight, Mrs. A. E. Brant, Mrs. E. H. Hake, Mrs. Dean Nesbit, Mrs. F. F. Piercy, Mrs. R. B. Poling. **Allen County**—Mrs. W. H. Beery, Mrs. Walter Noble, Mrs. J. R. Tillotson. **Ashland County**—Mrs. Robert Bogniard, Mrs. Geo. Riebel. **Belmont County**—Mrs. C. W. Lose. **Butler County**—Mrs. C. P. Atkinson, Mrs. Fred Brosius, Mrs. C. I. Stafford.

Columbiana County—Mrs. R. T. Holzbach. **Crawford County**—Mrs. D. D. Bibler, Mrs. E. C. Brandt, Mrs. Claude Lingenfelter. **Highland County**—Mrs. Maurice Hoyt, Mrs. W. B. Roads. **Jefferson County**—Mrs. S. J. Podlewski. **Knox County**—Mrs. Geo. Imhoff, Mrs. O. W. Rapp, Mrs. Julius Shamansky.

Marion County—Mrs. J. G. McNamara. **Richland County**—Mrs. C. H. Bell, Mrs. R. D. Campbell, Mrs. Robert L. Garber, Mrs. Leonard Hautzenroeder, Mrs. J. L. Stevens. **Ross County**—Mrs. Walter C. Breth, Mrs. Geo. W. Cooper, Mrs. W. B. Smith.

Scioto County—Mrs. Clyde Fitch, Mrs. A. P. Hunt, Mrs. Frank Siedenburg, Mrs. W. M. Singleton, Mrs. Walter Sisson. **Seneca County**—Mrs. Paul Leahy. **Stark County**—Mrs. James Bahrenburg, Mrs. Emerson Gillespie, Mrs. Chas. Paradis, Mrs. R. L. Rutledge, Mrs. Homer Weaver, Mrs. Geo. M. Wilcoxon.

Trumbull County—Mrs. E. G. Caskey. **Tuscarawas County**—Mrs. J. W. Calhoon, Mrs. D. H. Downey, Mrs. R. J. Foster, Mrs. C. J. Miller. **Washington County**—Mrs. S. E. Edwards, Mrs. R. W. Riggs, Mrs. J. F. Weber.

Maude Slye, ScD., since 1926 associate professor of pathology, University of Chicago School of Medicine, will retire from the University on July 1. In her notable career in cancer research during 38 years, the University states that Dr. Slye has observed 108 generations of mice, keeping records of 150,000 of their family trees.



When a patient seeks advice on the

ADEQUACY

OF INTERNAL MENSTRUAL PROTECTION...

Both in independent laboratory tests and in careful clinical studies, Tampax tampons have been shown to possess a wide margin of safety in providing for intravaginal absorption of the flux.

Though variations, of course, occur in the amount of blood lost during the period—most women have been found to conform within relatively narrow departures from the average of 50 cc.[1].

Even *Junior Tampax* provides amply adequate protection—with its absorptive capacity of 20 cc. for *each tampon,* or 200 cc. for the period (10 tampons are usually considered an ordinary month's supply). In addition, *Regular Tampax* has a capacity of 30 cc., and *Super Tampax* 45 cc. for *each tampon.* (or 300-450 cc. for the period).

In a recent study[2] of 110 young nurses employing Tampax tampons for catamenial protection, it was found that "95 per cent used tampons with satisfaction all through menstruation."

In another series[3], 18 (or 90%) of 21 subjects had "complete protection" Also "complete protection was afforded in 68 (94%) of 72 periods reported."

Other clinicians[4], investigating "twenty-five women under close institutional observation", noted that "with a tampon of proper size, absolute comfort and complete control of the flow can be obtained . . . the obvious advantage of the small, medium and large sized tampon of the particular brand (Tampax) is to be noted."

The results of this research parallel the experience of thousands of women who have found that Tampax affords thoroughly adequate protection.

(1) Am. J. Obst. & Gyn., 35:839, 1938. (2) West. J. Surg., Obst. & Gyn., 51:150, 1943. (3) Clin. Med. & Surg., 46:327, 1939. (4) Med. Rec., 155:316, 1942.

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Ohio Physicians Will Take Prominent Part in Annual Session of A.M.A. in Chicago, June 12-16

THE Ninety-Fourth Annual Meeting of the American Medical Association will be held in Chicago, Monday through Friday, June 12-16, with general registration and technical exhibits at the Hotel Stevens; sessions of the House of Delegates, general scientific meetings and the scientific exhibit at the Palmer House, and section meetings in various Chicago hotels.

The House of Delegates will convene at 10:00 A.M., Monday, June 12. The Ohio State Medical Association will be represented by: Dr. Barney J. Hein, Toledo; Dr. Parke G. Smith, Cincinnati; Dr. Wm. M. Skipp, Youngstown; Dr. George A. Woodhouse, Pleasant Hill; Dr. Harry V. Paryzek, Cleveland; Dr. Edward J. McCormick, Toledo; Dr. Carl R. Steinke, Akron; and Dr. C. C. Sherburne, Columbus. Dr. Clyde L. Cummer, Cleveland, is a member of the House of Delegates, representing the Section on Dermatology and Syphilology of the A.M.A.

OHIOANS ON IMPORTANT COUNCILS

Ohioans who are members of important councils, which will report to the House of Delegates, are: Dr. Geo. Edw. Follansbee, Cleveland, chairman, Judicial Council; Dr. Russell L. Haden, Cleveland, Council on Medical Education and Hospitals; Dr. Cummer, Council on Scientific Assembly; Dr. McCormick, Council on Medical Service and Public Relations; Dr. Torald Sollmann, chairman, and Dr. H. N. Cole, Cleveland, Council on Pharmacy and Chemistry.

The Scientific Assembly of the Association will open with a general meeting at 8:00 P.M., Tuesday, June 13. Section meetings will be held Wednesday, Thursday and Friday, June 14-16. The following sections will meet at 9:00 A.M. each day: Practice of Medicine; Obstetrics and Gynecology; Laryngology, Otology and Rhinology; Pathology and Physiology; Preventive and Industrial Medicine and Public Health; Urology; Orthopedic Surgery; Anesthesiology; Miscellaneous Topics (Sessions for the General Practitioner).

PANEL DISCUSSIONS

Convening at 2:00 P.M. each day will be the following sections: Surgery, General and Abdominal; Ophthalmology; Pediatrics; Experimental Medicine and Therapeutics; Nervous and Mental Diseases; Dermatology and Syphilology; Gastro-Enterology and Proctology; Radiology.

Features of the meeting include panel discussions on penicillin, tropical medicine, chemotherapy, plasma, neuropsychiatry, vitamins, amino acids and enzymes, and special exhibits on fractures, treatment of burns, chemotherapy and infectious diseases, and rehabilitation.

Throughout the week a regular schedule of motion pictures will be presented under the auspices of the Committee on Scientific Work in the Casino at the Morrison Hotel.

A specially arranged feature for the session is the war meeting planned for Wednesday night, June 14, at the Medinah Temple. This program will include not only the Surgeons General and other distinguished representatives of our armed forces, but also representatives of some of the United Nations.

BUCKEYE PARTICIPANTS

Ohio physicians scheduled to take part in scientific sessions, either as speakers or discussants, include: Dr. Charles A. Doan and Dr. George M. Curtis, Columbus; Col. Julien E. Benjamin, Dr. Leon Goldman, Dr. Carl A. Wilzbach, Dr. M. A. Blankenhorn, Cincinnati; Dr. Thomas E. Jones, Dr. John A. Toomey, Dr. Harold D. Green, Dr. J. P. Quigley, Dr. Bruno Gebhard, Dr. Everett N. Collins, Dr. R. J. Whitacre, Cleveland; Lt. Col. John E. L. Keyes, Youngstown; Dr. Forrest W. Merica, Lakewood.

Officers of scientific sections include the following Ohioans: Dr. Theodore A. Willis, Cleveland, vice-chairman, and Dr. James A. Dickson, member of the executive committee, Section on Orthopedic Surgery; Dr. John T. Murphy, Toledo, Section on Radiology; Dr. J. Craig Bowman, Upper Sandusky, chairman, Section on Miscellaneous Topics (Sessions for the General Practitioner).

Participants in special exhibits and conferences include; Dr. Samuel L. Robbins and Dr. C. Glenn Barber, Cleveland; Dr. Ralph G. Carothers, Cincinnati; and Dr. James R. Tillotson, Lima—fractures; Dr. Vinton E. Siler, Cincinnati—burns; Dr. R. W. Scott, Cleveland; and Dr. W. H. Bunn, Youngstown—heart disease.

WILL SHOW EXHIBITS

Among those who will present scientific exhibits are: Dr. Leon Goldman, Dr. Joseph B. Homan, Dr. Nancy Nurnham, Dr. Robert Kehoe, Dr. Joseph Treon, Dr. William E. Crutchfield, Jr., and Dr. Karl V. Kitzmiller, Cincinnati; Dr. H. S. Van Ostrand and Dr. Charles R. Hughes, Cleveland; Dr. J. M. Denardi, Lorain; and Dr. Morris G. Carmody, Painesville.

Representatives to the Scientific Exhibit from the various sections include: Lt. Col. Derrick Vail, Cincinnati, ophthalmology; Dr. Sterling H. Ashmun, Dayton, pediatrics; Dr. Paul A. Davis,





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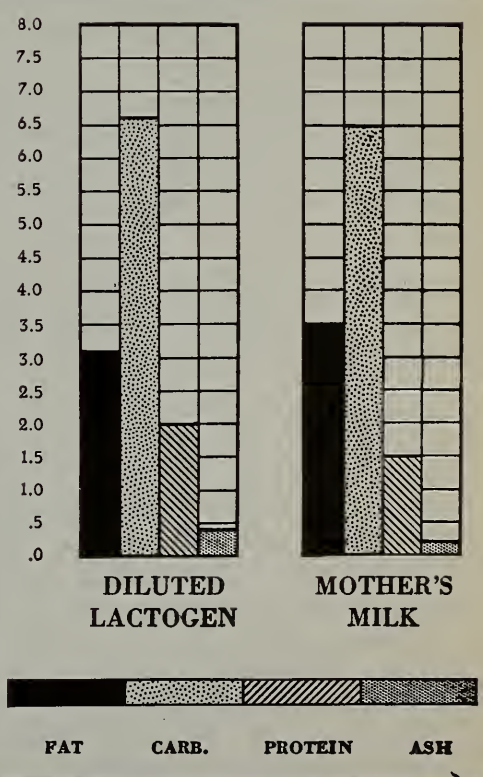
THE cows' milk used for Lactogen is scientifically modified for infant feeding. This modification is effected by the addition of milk fat and milk sugar in definite proportions. When Lactogen is properly diluted with water it results in a formula containing the food substances—fat, carbohydrate, protein, and ash—in approximately the same proportion as they exist in women's milk.

One level tablespoon of LACTOGEN dissolved in 2 ounces of water (warm, previously boiled) makes 2 ounces of LACTOGEN formula yielding 20 calories per ounce.

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—John Lovett Morse, A.M., M.D.
Clinical Pediatrics, p. 156.



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THOSE ELIGIBLE TO ATTEND

Only Fellows, Affiliate, Associate and Honorary Fellows and invited guests may register and take part in the work of the scientific sections. Fellows of the Scientific Assembly are those who have, on the prescribed form, applied for Fellowship, subscribed to *The Journal*, and paid their Fellowship dues for the current year. Fellowship cards are sent to all Fellows after payment of annual dues. These cards should be presented at the registration window. It will be possible for members of the Association to qualify as Fellows at Chicago, by presenting their state membership card, along with an application for Fellowship, at the booth in the registration headquarters marked "Applicants for Fellowship and Invited Guests".

Members attending the meeting are cordially invited to visit the headquarters of the American Medical Association, 535 North Dearborn Street, at any time during the annual session, June 12 to 16, from 8:30 A.M. to 5:00 P.M. A staff of guides will be available to conduct visitors through the nine-story building which houses the many activities of the Association.

The Twenty-Second Annual Meeting of the Woman's Auxiliary to the American Medical Association will be held at the Hotel Knickerbocker, June 13-15. Members of the Auxiliary and the wives and guests of physicians present at the A.M.A. meeting are cordially invited to participate in the social functions and attend the sessions.

For complete details concerning the program for the annual meeting of the American Medical Association and the Woman's Auxiliary, see pages 40-70, May 6 issue, *J.A.M.A.*

Narcotic License Must Be Renewed By July 1 to Avoid Penalty

On or before July 1 every physician registered under the Harrison Narcotic Act, must, unless he is in military service, re-register with the Collector of Internal Revenue of the district in which he maintains an office, and pay the Federal Narcotic Tax of $1.00. Initial applications may be made at any time, but existing permits must be renewed on or before July 1, annually.

Failure to re-register within the time allowed by law adds a penalty of 25 per cent to the annual tax, and in addition makes the physician liable to a fine not exceeding $2,000 or to imprisonment for not more than five years or both. In recent years the Commissioner of Internal Revenue has given some tardy registrants the choice between paying sums by way of compromise in lieu of the penalties for their offenses, or as an alternative, accepting criminal prosecution, with resultant publicity and liability to fines and possible imprisonment. Strict adherence to the law will obviate the necessity for such action and protect the physician from needless embarrassment.

Copies of the forms for re-registration have been mailed by the District Collectors of Internal Revenue to each Ohio physician already registered, with brief instructions of the procedure to be followed. For several years the collectors sent a second notice about June 15 to physicians who had failed to re-register. This was discontinued last year, and there will be no reminder this year.

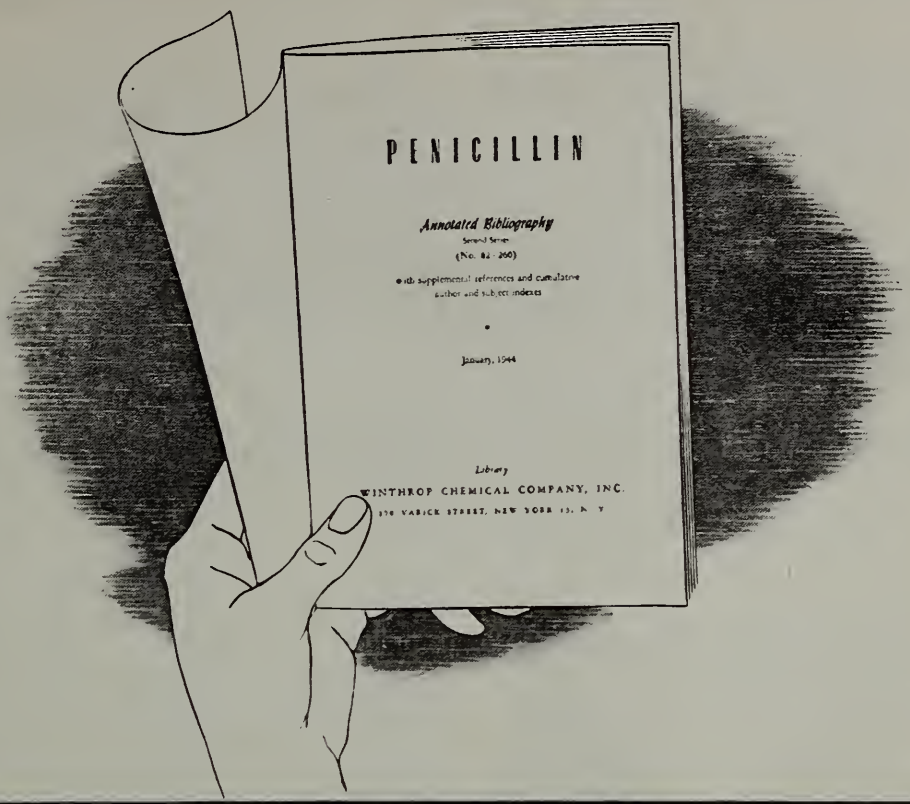
Application for re-registration must be made on Form 678, signed by the physician applying, and either acknowledged by two qualified witnesses or sworn to by a Notary Public or an official of the Internal Revenue Department. The physician must note on his application the number of his license to practice medicine in Ohio. The registration number assigned by the Department of Internal Revenue is retained from year to year. Remittance accompanying the application may be in the form of cash, a postal money order or certified check. Personal checks, not certified, will be returned to the sender.

An inventory of the narcotic drugs on hand in the physician's office must accompany the application, on Form 713. The regulations require that this inventory must be sworn to by a Notary Public or an official of the Internal Revenue Department regardless of the quantity of drugs on hand.

Physicians who administer, dispense or prescribe cannabis, must obtain a special permit under the Marihunana Tax Act, and re-register annually on or before July 1, with the Collector of Internal Revenue of his district, and pay a tax of $1.00.

A physician in the armed forces need not re-register. If such a physician should receive an application form for re-registration he should return it to the office of the Collector of Internal Revenue from which it was sent, together with a statement that he is in the armed forces, that he does not have in his possession any narcotics, and requesting that the registration number previously assigned to him be reserved.

A physician on entering service, who wishes to discontinue registration under the Harrison Narcotic Act, should return all unused order forms to the collector's office, and should dispose of all narcotics on hand, either by returning them to the wholesale concern from which purchased, if the packages are in unbroken form, or by transferring the narcotics to another physician, after having obtained permission for such transfer from the office of the Collector of Internal Revenue with whom he is registered.



SECOND SERIES NOW AVAILABLE

• We will gladly send (gratis) to physicians a copy of this handsomely printed booklet on Penicillin. This is a highly informative and up-to-date annotated bibliography with supplemental references and cumulative author and subject indexes.

The entire production of Penicillin is currently under Government allocation. A substantial portion is being released for civilians. Through increased production Winthrop has helped to meet the great need for Penicillin.

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Increase Made in Military Roster; Total Number of Ohio Physicians Now In Various Services Is 2,789

MILITARY Roster of the Ohio State Medical Association stood at 2,789 on May 17, 1944, as this issue was made ready for the presses. Of the Ohio physicians in the armed forces or in full-time government services for the duration, 2,361 were in the Army, 362 in the Navy, and 66 in miscellaneous services. During the past month the names of 12 physicians were added to the Military Roster.

The Journal would appreciate being advised promptly when a physician enters the service, so his name can be added immediately to the Military Roster.

Following are the names recently added to the Military Roster, medical officers receiving promotions, and a breakdown of the total by counties:

NAMES ADDED TO MILITARY ROSTER

Name	City	Rank
Alpert, Sidney	Cleveland	1st Lt., U.S.A.
Bellamy, Curtis F.	Cincinnati	Lt. Comdr., U.S.N.
Bieser, Dietrich R.	Dayton	1st Lt., U.S.A.
Burt, Olan P.	Columbus	1st Lt., U.S.A.
Crossett, Homer A.	Lindsey	Vet. Admin.
Froug, Charles	Dayton	1st Lt., U.S.A.
Hillegass, Victor E.	Akron	1st Lt., U.S.A.
Jackson, E. L.	Shelby	Lt., U.S.N.
Mathias, Charles W.	Niles	1st Lt., U.S.A.
Rose, James E.	Sabina	1st Lt., U.S.A.
Sholl, John G.	Cleveland	1st Lt., U.S.A.
Somsel, Clarence P.	Dayton	1st Lt., U.S.A.

WIN PROMOTIONS

Name	City	Rank
Bean, Wm. B.	Cincinnati	Major, U.S.A.
Berns, Charles	Cleveland	Lt. Col., U.S.A.
Black, Sam H.	Akron	Comdr., U.S.N.
Boyer, Byron E.	Cincinnati	Lt. Col., U.S.A.
Brody, Melvin	Canton	Capt., U.S.A.
Bubna, Louis Edw.	Cleveland	Capt., U.S.A.
Chamberlin, Clyde G.	Shaker Heights	Capt., U.S.A.
Devanney, John W.	Cincinnati	Capt., U.S.A.
Dillahunt, Paul H.	Columbus	Capt., U.S.A.
Epstein, Francis W.	Toledo	Capt., U.S.A.
Galbreath, Walter F.	Findlay	Major, U.S.A.
Glover, Donald M.	Cleveland	Lt. Col., U.S.A.
Goodman, David H.	Cleveland	Capt., U.S.A.
Gross, Alex	Cleveland Hgts.	Capt., U.S.A.
Halley, John	Vermillion	Capt., U.S.A.
Hattenbach, J. F.	Cleveland	Capt., U.S.A.
Haubrich, Robert C.	Pataskala	Major, U.S.A.
Houghton, Ben C.	Columbus	Major, U.S.A.
Howard, Kenneth R.	Toledo	Major, U.S.A.
Hoyt, Walter A., Jr.	Akron	Capt., U.S.A.
Ivins, Paul N.	Hamilton	Major, U.S.A.
Katz, L. B.	Dayton	Capt., U.S.A.
Kimmel, A. H.	Norwalk	Major, U.S.A.
Kirk, Gilman	Columbus	Major, U.S.A.
Knies, Phillip T.	Columbus	Lt. Col., U.S.A.
Lamb, A. J.	Cleveland	Capt., U.S.A.
Leyrer, Carl A.	Hamilton	Capt., U.S.A.
Lowenthal, Gerson	Cincinnati	Major, U.S.A.
Merrill, Robert	Delta	Capt., U.S.A.
Moore, Wm. Arthur	Cincinnati	Capt., U.S.A.
Ondash, Stephan W.	Youngstown	Major, U.S.A.
Pease, Philip P.	Chardon	Col., U.S.A.
Pospisil, R. J.	Springfield	Capt., U.S.A.
Prochaska, Charles J.	South Euclid	Lt. Col., U.S.A.
Reading, Robert A.	Cleveland	Comdr., U.S.N.
Snively, Lloyd M.	Massillon	Capt., U.S.A.
Speed, Geo. W.	St. Marys	Major, U.S.A.
Switzer, M. E.	Galion	Capt., U.S.A.
Tagett, H. A.	Ashtabula	Lt. Comdr., U.S.N.
Tischler, Geo. A.	Cleveland	Lt. Col., U.S.A.
Wagner, Gordon T.	E. Cleveland	Capt., U.S.A.
Wagner, John L.	New London	Capt., U.S.A.
Walzer, Leo	Cleveland	Major, U.S.A.
Wiggers, Russell F.	Cincinnati	Capt., U.S.A.
Wilcox, John M.	Cleveland	Capt., U.S.A.
Wilson, Gerald N.	Columbus	Major, U.S.A.
Wolpaw, B. J.	Cleveland	Comdr., U.S.N.

TABULATION BY COUNTIES

Adams 2	Guernsey 7	Muskingum .. 10
Allen 37	Hamilton 432	Noble 0
Ashland 11	Hancock 13	Ottawa 9
Ashtabula 17	Hardin 7	Paulding 2
Athens 11	Harrison 4	Perry 4
Auglaize 6	Henry 2	Pickaway 5
Belmont 14	Highland 8	Pike 2
Brown 4	Hocking 4	Portage 2
Butler 30	Holmes 2	Preble 7
Carroll 1	Huron 15	Putnam 6
Champaign ... 9	Jackson 1	Richland 38
Clark 31	Jefferson 28	Ross 24
Clermont 9	Knox 10	Sandusky 11
Clinton 8	Lake 18	Scioto 20
Columbiana .. 11	Lawrence 6	Seneca 12
Coshocton 4	Licking 17	Shelby 7
Crawford 9	Logan 8	Stark 98
Cuyahoga 677	Lorain 38	Summit 147
Darke 6	Lucas 155	Trumbull 27
Defiance 4	Madison 6	Tuscarawas .. 20
Delaware 7	Mahoning 117	Union 2
Erie 10	Marion 16	Van Wert.... 9
Fairfield 9	Medina 12	Vinton 2
Fayette 2	Meigs 3	Warren 4
Franklin 224	Mercer 6	Washington .. 8
Fulton 6	Miami 13	Wayne 14
Gallia 5	Monroe 1	Williams 8
Geauga 4	Montgomery .144	Wood 18
Greene 6	Morgan 3	Wyandot 3

Total 2789

Dr. Barney J. Hein, Toledo, Chairman of the Committee on Industrial Health of the Ohio State Medical Association, and Dr. Christopher Leggo, Columbus, Chief, Industrial Hygiene Section, State Department of Health, participated in a panel discussion on "Standing Orders for Nurses in Industry", at a meeting of the Section on Industrial Nursing during the Forty-First Annual Convention of the Ohio State Nurses' Association, May 19-20, at Columbus.

Dr. Arnold D. Welch, research director of Sharpe and Dohme, Philadelphia, has been appointed head of the department of pharmacology of Western Reserve University School of Medicine, succeeding Dr. Torald H. Sollmann, who will retire on June 30.

The American Psychiatric Association held its centennial meeting in Philadelphia, May 15-18. Founded in Philadelphia 100 years ago by 13 pioneering psychiatrists, the group now includes more than 3,000 members.

Ohio paid out $1,118,193.64 for the redemption of sales tax stamps to charitable organizations during 1943.

BROADENING THERAPEUTIC APPLICATIONS OF *Estrogenic Hormones*

It was only a few years ago that medical writers were inclined to question the potency and therapeutic efficacy of estrogenic substances. Today, with well defined standards of activity, and with preparations of a purity and activity unheard of less than two decades ago, estrogenic hormones have a well established place in medical practice.

The broadening therapeutic application of estrogenic hormones is well documented by acceptance of the Council on Pharmacy and Chemistry of uses which, in some instances, were unheard of five years ago. At present the accepted uses include the following:

Menopausal symptoms . . . Senile vaginitis . . . Kraurosis vulvae . . . Gonorrheal vaginitis of children . . . Painful engorgement of the breasts in puerperium . . . Carcinoma of prostate . . . Functional uterine bleeding of probable endocrine origin . . . Suppression of lactation under certain conditions.



Amniotin—a solution of natural estrogens—is available in a variety of dosage forms and potencies. For certain other uses, such as in the suppression of lactation and the checking of functional uterine bleeding, the high activity of orally administered Diethylstilbestrol commends itself. Diethylstilbestrol Squibb likewise is available in a variety of dosage forms. Recent reports[1] suggest that the nausea which frequently accompanies its initial use becomes less serious as patients gain a tolerance to its administration.



[1] *Jl. Clin. Endocrinology* 3:648, Dec. 1943.

For literature write the Professional Service Dept., 745 Fifth Ave., New York 22, N. Y.

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BUY AN EXTRA WAR BOND

WAR NOTES

Congratulations to Capt. Walter M. Simpson, Dayton, now stationed at the U.S. Naval Hospital, Long Beach, Calif., as chief of medicine! Dr. Simpson has been awarded a letter of commendation from the Secretary of the Navy "for meritorious performance of duty while serving as chief of medicine, and later as executive officer of the first advanced naval base hospital to be established in the South Pacific area during the period from April 12, 1942, to Nov. 1, 1943".

Captain Simpson headed a naval hospital unit whose members were well-known Dayton physicians, the first to set up in the South Pacific battle zone. Of his services at this time the citation states: "Captain Simpson reflected great credit on himself by his outstanding professional ability, leadership and keen judgment. As liaison officer he dealt with officials of foreign nations with tact and diplomacy, thus contributing materially to the harmonious relations with foreign nations . . . His courageous conduct was in keeping with the highest tradition of the United States naval service."

* * *

From the Marshall Islands writes Capt. Harry H. Robinson, Cleveland, that he is real proud (as well he should be) to be in the first outfit to capture the first Jap-held territory. In addition to his Army medical duties he is in charge of the medical care of natives in a neighboring island. One of the native couples named their newborn infant after him, and he has been made an honorary chief, even to the extent of being adorned with a crown made up of small seashells.

* * *

Major H. M. Amstutz, Lancaster, with an evacuation hospital unit in England, of which Major Clovis Phillips, Cleveland, also is a member, writes that he had a three weeks' tour of duty at the London Ophthalmic Hospital, where he had an unusual opportunity to observe their treatment of retinal detachments. He adds, blessings on him, "somehow I always feel a little pride in showing our *Journal* to medical officers from other states, and I frequently get some very complimentary remarks about it".

* * *

Located "right on the ocean, somewhere in New Guinea", Capt. W. B. Andrus, Columbus, executive officer of a station hospital, sends greetings to his former colleagues. He is burned up about strikes and the Wagner Bill, as aren't we all?

Capt. D. W. Brickley, Jr., Marion, is at the Borden General Hospital, Chickasha, Okla.

* * *

Major Harry G. Conn, Toledo, has been transferred to the Ninth Corps Area, San Francisco, after two months at Hines, Ill.

* * *

Lt. Col. H. E. Caldwell, Delaware, is CO of the 137th General Hospital, Camp Butner, N.C.

* * *

Capt. Wm. F. Mitchell, Columbus, is flight surgeon with a heavy bombardment squadron in India.

* * *

The Journal helps him pass the time between shells, writes Major A. O. Diggs, Mansfield, "a close-up medical supporter" with an infantry regiment in combat in the South Pacific.

* * *

Major Arthur Dobkin, Akron, chief of the communicable disease section in a general hospital, England, writes that there are several Ohioans in his outfit, including Major Wm. F. Vinnedge, Hamilton. He recently saw Major George L. Hardgrove, Doylestown, chief of medicine of a station hospital there.

* * *

Major John C. Drake, Mt. Vernon, with a general hospital unit in the jungles of New Guinea, says: "We are getting to be real jungle engineers and campers, as well as medicos". Major Harrison S. Evans, Columbus, is chief of neuro-psychiatry in the unit. Dr. Drake reports having seen Dr. Dick Sharkey, a recent graduate of Ohio State, now in the Navy.

* * *

Major A. C. Ormond, Zanesville, is chief of surgery in a general hospital, now in England.

* * *

Lt. Wm. S. Oliver, Middleport, is in "a fairly isolated spot", with a portable surgical hospital unit, somewhere overseas.

* * *

Lt. Col. P. C. Pennington, Findlay, is attached to the Veterans' Administration, Dallas, Texas.

* * *

Capt. Joseph F. Hattenbach, squadron flight surgeon with a B-17 unit in Italy would like to see some of his former Cleveland colleagues. He has been overseas for 14 months and during that time has seen "all of Northern Africa, Sicily, Sardinia, Corsica, and what we have of Italy".



IN THE *Progressive* NUTRITIONAL NEEDS OF GESTATION

While it is not strictly true that the gravid woman must "eat for two," nutritional requirements nevertheless are higher during pregnancy. As the fetus increases in size, its nutritional demands increase. In consequence, food consumption must be progressively raised to prevent catabolic breakdown of maternal tissue to satisfy these needs.

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PROTEIN	6.0 Gm.	31.2 Gm.	VITAMIN A	1500 I.U.	2953 I.U.
CARBOHYDRATE	30.0 Gm.	62.43 Gm.	VITAMIN D	405 I.U.	480 I.U.
FAT	2.8 Gm.	29.34 Gm.	THIAMINE	.9 mg.	1.296 mg.
CALCIUM	.25 Gm.	1.104 Gm.	RIBOFLAVIN	.25 mg.	1.278 mg.
PHOSPHORUS	.25 Gm.	.903 Gm.	NIACIN	3.0 mg.	5.0 mg.
IRON	10.5 mg.	11.94 mg.	COPPER	.5 mg.	.5 mg.

*Each serving made with 8 oz. of milk; based on average reported values for milk.

He continues: "I like my work a lot. It consists mainly of keeping them flying but also some good medicine and surgery. I have been on a few missions over enemy territory and can tell you that when the flak begins to fly it is quite a thrill. I think our flyers deserve all the credit that we can give them as they are really doing a fine job. We are stationed in a nice big open field as usual and live in the nicest tents, not quite like home, if you know what I mean. With Italian labor we have constructed mess hall, clubs, showers and some offices."

* * *

Chief of neurosurgery at the U.S. Naval Hospital, Treasure Island, San Francisco, is the assignment of Lt. Wm. A. Nosik, formerly of the Cleveland Clinic. Says Dr. Nosik: "Private and independent enterprise in the practice of medicine is one of its most desirable features. Let's keep it that way. Regimentation must be experienced to be appreciated fully. We acknowledge its necessity for the duration only." A vast majority of your colleagues, both in and out of the service, feel the same way about it, doctor!

* * *

Capt. A. D. Robertson, Willard, was recently transferred from the Station Hospital, Jefferson Barracks, Mo., to the A.A.F. Convalescent Center, Rawling, N.Y., "a beautiful spot".

* * *

Selfridge Field, Mt. Clemens, Mich., is the new location of Capt. Lovell W. Rohr, Columbus, previously at the Richmond Army Air Base, Va.

* * *

Capt. George B. Watson, Columbus, is with a general hospital unit in North Africa. Recalling our family doc's allergy to hot weather, we imagine he'd prefer to be back in Alaska, where he was stationed last year.

* * *

Major Robert Haubrich, Jr., Pataskala, flight surgeon with the forward echelon of the 7th Bomber Command in the Southwest Pacific, was among 10 officers who were specially commended by Brig. Gen Walter J. Reed for work performed by an advance detachment of officers and enlisted men.

* * *

Capt. William E. Russell, Genoa, is a battalion surgeon with glider troops in England.

* * *

Commanding officer of an evacuation hospital unit operating in the field of combat in the South Pacific, is the tough assignment of Lt. Col. Thomas M. Kirk, Dayton. Previously in New Guinea, Dr. Kirk writes: "We have moved farther north and are practically on the equator now. . . . We have been bombed and strafed, but very lucky that none of the hospital staff became casualties. The officers and men of the hospital have accomplished wonderful things, and I am proud and grateful of their work. The unit has also received high praise and commendation from the line officers in command of this invasion. Surgery and medicine under these conditions are hard to imagine unless they have been experienced."

* * *

Capt. Wm. H. Eberle, Ashtabula, is with a convalescent hospital unit in New Caledonia.

* * *

Capt. David M. Goodman, Cleveland, formerly at the Station Hospital, Fort Hayes, is now on the staff of the Wakeman General Hospital, Camp Atterbury, Ind.

* * *

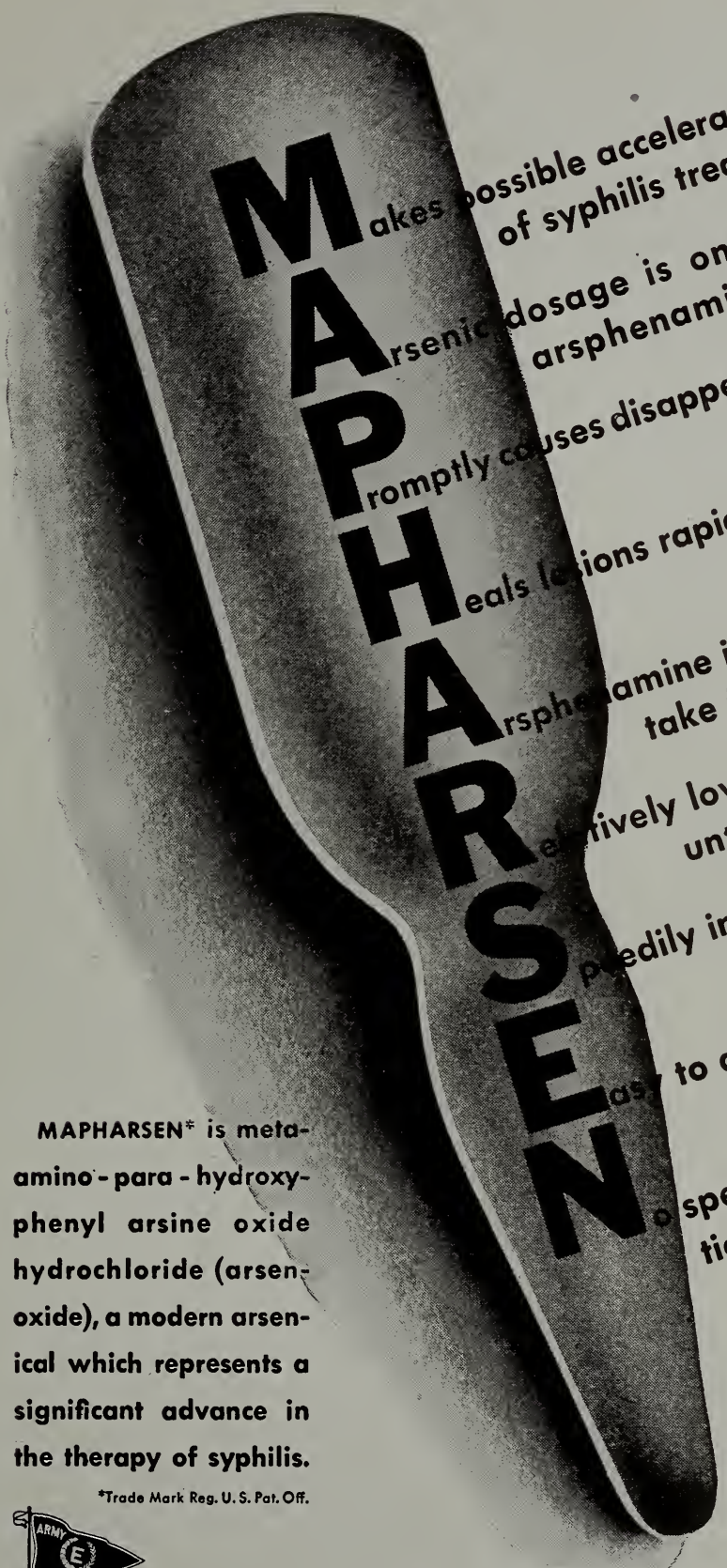
Major Emmerich Von Haam, Columbus, is now stationed overseas, but we can't tell where.

* * *

An interesting letter from Lt. Col. Donald M. Glover, Cleveland, chief of surgical service with a general hospital unit in the South Pacific, recalls a meeting of the State Association's Sub-Committee on Workmen's Compensation in the State Headquarters Office, Columbus, Sunday, December 7, 1941. Five of the seven physicians who attended that meeting are now in the service. They are: Lt. Col. Glover; Comdr. Drew L. Davies, Columbus, with a naval hospital unit in the South Pacific; Major Malcolm O. Cook, Hamilton, in Italy with a general hospital attached to the Fifth Army; Major Robert L. Eastman, Mt. Vernon, at the Regional Station Hospital, McClelland Field, Sacramento, Calif., and Comdr. Henry P. Worstell, Columbus, recently transferred from the Navy's Pre-Flight School at Iowa City to San Francisco for probable fleet duty. The two other physicians at the meeting were Dr. Harry V. Paryzek, Cleveland, then President of the State Association, and Dr. Barney J. Hein, Toledo, chairman of the committee. Both served in the Medical Corps of the U. S. Army in France in World War I, which makes that committee's military record 100 per cent.

Following are some excerpts from Dr. Glover's letter:

"A lot of blood and water has gone over the dam since that fateful day we were having our Industrial Committee meeting in Columbus, at the same time that things were happening that started this fracas, and the day a month later when we were pulled out and sent overseas. After over two years in a metropolitan area, we are now transplanted to a beautiful jungle setting. Just as we were the first general hospital to be established overseas, we are the first to be in operation this far forward, in this theater. The vicissitudes of transplanting an organization of this size with equipment, over archaic railroads, modern ships, and various amphibious critters were really something for the book. The experience has been interesting, although one has the vaguely unpleasant feeling that a good deal of



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the effort is unproductive. We have been indeed fortunate in our assignments, however, and are duly thankful. Inactivity would be hard for me to take, and fortunately I have had very little of it.

"We have accumulated a fairly interesting lot of data and experiences, most of which are not amenable to discussion at the moment, but will be later. Thanks for your interest, and I hope that before too many months more roll around we'll be meeting again."

* * *

The Distinguished Service Medal has been awarded Maj. Stephen W. Ondash, Youngstown, and did he earn it! Just read this citation from the War Department:

"Exceptionally meritorious conduct in the performance of outstanding service from September, 1941, to April, 1942.

"During that period he served as surgeon for United States Engineer Department employees and a group of civilian workers at a barren and desolate station in Greenland, north of the Arctic Circle.

"Given four engineer employees without previous medical or surgical experience, he trained them to competency and instructed the only other officer in the detachment until he qualified as an anesthetist.

"Despite the rigorous weather and wind conditions at this isolated position, coupled with lack of equipment facilities, his skill was such that no loss of life occurred among the station personnel.

"His work was such as to secure the confidence of all employees and heighten their morale and efficiency."

* * *

Helping take care of the Armored Force men at Camp Chaffee, Ark., is the new assignment of Captain Lawrence W. Weller, Youngstown, assistant chief of dispensary service at the station hospital there.

* * *

Capt. John L. Wagner, New London, acknowledges receipt of his 1944 membership card in New Guinea, where he is with an airdrome squadron.

* * *

Major Alven M. Weil, Akron, is on the medical staff of an Army hospital ship.

* * *

Another Ohio physician recently decorated is Capt. William M. Kuntz, Columbus, Ohio State graduate of 1940, who received the Bronze Medal at Fifth Army Hdqrs. in Italy for meritorious conduct while serving with an armored unit.

* * *

"The German prisoner captured in Italy is a husky, well-fed, well-equipped youth. He's glad to be out of the war, but he's confident that Hitler will win in about a year and no one can tell him that New York hasn't been bombed", says Capt. Louis J. Crum, Cincinnati, home on a 30-day leave after eight months overseas.

Ohio is represented at the U. S. Naval Training Station, Newport, R.I., by Lt. Comdr. Paul E. Kellogg, Ashland, chief of surgery, and Lt. Comdr. Marvin B. Goldstein, Youngstown, chief of dermatology.

* * *

Lt. Col. Y. N. Pitkin is a convalescent at Crile General Hospital in his home town, Cleveland.

* * *

Capt. O. J. Lamb, Cleveland, is chief of EENT with a station hospital in Italy. Also in Italy, with a medical battalion, is Capt. Ralph J. Kessler, Cincinnati.

* * *

Capt. Joseph Heiman, Cleveland, en route overseas, apparently Africa, did an emergency appendectomy aboard ship. Here's his story, and it's a good one:

"The trip was uneventful. We were safe at all times, and well-protected. On board I was the only doctor, hence was ship's surgeon and had a private stateroom, even a bed lamp. The food was good. I had a seat in the dining room with the captain and ship's officers—but also ate many meals with the men. For diversion—about a week out from the States we had an emergency appendectomy. The lad was a navy gunner attached to the ship—a pink-cheeked Italian kid of 18—with dimples, a ready smile, and pleasing ways. The facilities were meager and major surgery of any kind on a small convoy vessel is approached with great respect. Treated him conservatively for eight hours but no improvement, so operated. There was a big roll running to complicate. My sergeant was first assistant, and my corporal was suture nurse. Neither had seen an appendectomy before, but they were splendid. We had to improvise in many ways—borrowed white caps from the cooks, improvised masks of gauze. The suture table was two G. I. garbage cans scrubbed and turned upside down. So the instruments wouldn't slide off the table the ship's engineer wired side boards to six inches above the top of cans, as the roll of the small ships is out of proportion to the size of sea that is running. After that I detailed one man to sit on the floor and keep the cans from sliding away, another to stand behind me and keep me upright at the table, and another behind the sergeant. The operating table was bolted to the floor—suture nurse had to shift for himself. The appendix was not hard to find but was difficult to remove due to pelvic adhesions. Because of the roll it took longer and I had to draft a Lt. Col. of Engineers to give ether at the end. Patient got along well and is up now, chipper as ever, at Naval Hospital ashore. Aside from a case of chicken pox and a suspected case of meningitis (I threw the book at him right away) the medical problems were the usual ones you get on sick call. My present quarters is 'Tent City'. The days are warm and comfortable, the nights cold as hell. Outside latrines. The food except for salads and fresh vegetables is good. Even cloth napkins—the first I have had in the army."

* * *

Ohio physicians who have assisted Army and Navy medical officers in doing physical examinations at induction centers for six months or more, were recently awarded the Emblem for Civilian Service by the War Department. A letter from

Remember in 1932 we brought out Pablum? A new concept of cereal nutrition, easy of preparation, non-wasteful, fore-runner of present-day widely practised principles of food fortification—remember?



Now we have gone a step further in Pabena, similar in nutritional and convenient features to its father-product, Pablum, different in flavor because of its oatmeal base. If our pioneer work and ethical conduct meet with your approbation, remember, please, to specify Pablum and Pabena.

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Col. E. C. Jones, M.C., Hdqrs., Fifth Service Command, Ft. Hayes, making the awards, reads as follows:

"It it with great satisfaction that this headquarters announces the award of the Emblem for Civilian Service to those civilian members of our profession who have answered their country's call to duty as co-workers with their military brothers in the joint enterprise of examining the nation's manpower.

"The professional demands of this great undertaking were fully appreciated by the War Department. From the very beginning it was clearly foreseen that here was a task of such proportions that the Army Medical Corps could not accomplish it alone and at the same time supply the tremendous numbers of physicians to Station, General, Evacuation and other Field Hospitals, and to Medical Regiments and Battalions operating with tactical units. In its very early planning the Office of the Surgeon General relied with the utmost confidence on the patriotism and self-sacrificing cooperation of this nation's medical profession. That confidence has not been misplaced. The spirit with which our fraters have given of their time and energy, often at great pecuniary loss, has been heartwarming and has engendered a deep feeling of pride in our profession.

"In awarding these emblems I bring to you the grateful thanks of our Government which has not been unmindful of the very important contribution which has been, and will continue, to be made by the civilian profession. I should like at the same time to convey my own personal thanks for your splendid spirit of cooperation."

* * *

Major Robert L. Thomas, Columbus, in Alaska many months, is base medical inspector, base venereal disease control officer; group surgeon for the Sixth Air Depot; U.S.P.H.S. and Territorial Department of Health inspector; reads all the electro-cardiograms for the base, also for the doctors in the town; has been on every board in the books, and was acting veterinary officer for one month! Outside of these jobs, he has had fun hunting moose, caribou and fowl, also some marvellous fishing. He hopes to get home in July.

* * *

Major Asher Randall, Youngstown, has been transferred from the Signal Depot, Lexington, Ky., to the Army General Hospital, Camp Atterbury, Ind.

* * *

Capt. Morris W. Selman, Toledo, reports "a swell assignment, with plenty of action", in a station hospital in England.

* * *

After 16 months in the Aleutians as a naval flight surgeon, Lt. Comdr. F. S. Hosking, Cleveland, has been assigned to the Naval Air Station, Oak Harbor, Whidbey Island, Wash.

* * *

Capt. Louis W. Schneider, Hamilton, is continuing his study of tropical diseases at a station hospital, San Juan, Puerto Rico.

Overseas for over a year with an auxiliary surgical group, Capt. James L. Kocour is now with a station hospital in North Africa.

* * *

Capt. D. L. Hirst, Miamisburg, writes home from the Cassino front in Italy that he heartily endorses Ernie Pyle's idea about combat pay for "the infantry and associated branches that win the wars". Awarded the Purple Heart, Dr. Hirst explained that his wound "was nothing at all. I got hit in the leg with a shell fragment. I didn't even go to the hospital. My boys fixed me up and I was on duty the next day."

* * *

Lt. Comdr. G. H. Castle, Cincinnati, finds time for his favorite recreation—deep-sea fishing—somewhere along an island in the South Pacific, where he is chief of surgery at a naval base hospital.

* * *

Capt. John E. Martin, Columbus, flight surgeon with the 8th Army Air Force in England, has been named assistant division surgeon.

* * *

England General Hospital at Atlantic City was dedicated on April 26, honoring the late Lt. Col. Thomas M. England, M.A.C., one of Dr Walter Reed's human "guinea pigs" in the now historic battle against yellow fever. Well known to many Ohio physicians as executive officer of the Fifth Service Command Medical Branch at Ft. Hayes, Col. England died on July 23, 1943. Mrs. England attended the dedication ceremonies, accompanied by a physician and a nurse.

* * *

The National Naval Center of Bethesda, Maryland, is endeavoring to collect for its archives a complete set of commissions issued to Naval medical officers, signed by past Presidents of the United States. Any individuals or libraries which have such old commissions in their possession and would be willing to turn them over to the center, are requested to communicate with Comdr. Robert C. Ransdell, M.C., U.S.N.R., Division of Publications, Bureau of Medicine and Surgery, Navy Dept., Washington 25, D.C.

* * *

Capt. Francis W. Epstein, Toledo, is with a medical detachment in Northern Ireland.

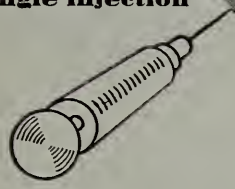
* * *

There was quite a stir one morning during the recent Annual Meeting of the State Association in Columbus when a two-star general strolled through the Technical Exhibit Hall. He was Maj. Gen. Robert H. Mills, chief dental officer of the Army Service Forces, in Columbus that day for the ceremonies at Fort Hayes when Lt. Gen. George Grunert, commanding general of the Eastern Defense Command, presented the Legion

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of Merit to Maj. Gen. Daniel Van Voorhis, ret., for outstanding service in the Caribbean area. Gen. Van Voorhis retired a few months ago as commanding general of the Fifth Service Command.

* * *

Capt. John M. Wilcox, Cleveland, is with an air service squadron in the Aleutians, where "life is boring and the weather despicable". He says there is an occasional interruption of the monotony, and sends the proof—a photograph of the doctor and Olivia DeHavilland, the movie star, seated in a quonset during her tour of the hospitalized soldiers throughout the entire Aleutian chain. Dr. Wilcox comments: "She did a wonderful job of morale building, and probably did more to forestall, if not actually prevent, psycho-neurosis among the enlisted men than any army medic ever could do."

By the way, in the April issue we requested group pictures of Ohio doctors in the service to be published in The Journal. As soon as we have enough for a page layout, the War Notes section will be pepped up by "art".

* * *

Major T. Victor Kolb, South Charleston, has been assigned to the staff of Crile General Hospital, Cleveland.

* * *

More about Clevelanders: Capt. T. A. Coffin, with a hospital unit in England, had time to attend surgical clinics in Manchester . . . Capt. L. J. Haas had a few days' refresher course in orthopedic surgery at a hospital on the outskirts of the famous Dartmoors . . . Lt. Col. George A. Tischler is CO of a Station Hospital located in an orphanage in a large city on the African coast . . . Last Summer the hospital took care of German and Italian prisoners and at times had over 900 patients . . . Lt. Comdr. George J. Greene "has been around" in the Pacific on patrol, e.g., the Samoans, Fijis, Tonga group, Australian coasts, Tasmania and other points.

* * *

Many Ohio physicians now in the Army will remember Major Norman R. Booher, Indianapolis, who was on duty in Ohio during the Summer of 1942 with the medical officers recruiting board. Now a Lieut. Col., he graduated from the Command and General Staff School, Fort Leavenworth, Kan., last Summer, and according to the grapevine, was assigned as executive officer of a general hospital unit now in England.

* * *

Dr. Robert G. Lehman, Dayton, was recently advanced to the rank of Lieut.-Comdr. in the Medical Corps of the regular Navy. He is in the Field Medical School Battalion, Camp Pendleton, Oceanside, Calif.

Capt. A. M. Karlan with an aviation medical dispensary in England reports two other Springfield physicians in his vicinity, Major Clouse and Capt. Pospisil. It's a small world!

* * *

Capt. Frederick B. Kaylor, Bellefontaine, is taking a three months' course in medicine and surgery at Walter Reed Hospital, Washington, D.C.

* * *

About Toledoans—Capt. Joe Hertzberg, South Pacific-bound with a general hospital unit . . . Comdr. J. Lester Kobacker, in a "Robinson Crusoe Hideaway", with a naval base hospital in the Solomons . . . Major Paul Leffler, on the staff of Brooke General Hospital, Fort Sam Houston, Texas, as is Capt. Wallace Morton . . . Capt. Ishbal Krishna was there as a patient recently, now at Valley Forge General Hospital, Phoenixville, Pa. . . . Lt. Comdr. C. A. Bayha, chief of medicine U. S. Naval Hospital, Norman, Okla. . . . Capt Matthew Ginsberg and Lt. Comdr. E. R. Garvin, recently home on leave . . . Capt. W. Brown, in Italy . . . Capt. Joe Radecki, reported wounded in action . . . Capt. John Seesholtz, with a field hospital in New Guinea . . . Capt. Joe Baird, Camp Hood, Texas.

* * *

Major Gerson Lowenthal, Cincinnati, chief of the ENT Section at Ashburn General Hospital, McKinney, Texas, was one of the guest speakers in the EENT Section at the recent annual meeting of the Texas State Medical Association.

* * *

First Lieut. William C. Craig, a flight surgeon with the AAF in the South Pacific, was killed in the line of duty on April 28. A graduate of Ohio State University College of Medicine in 1935, Dr. Craig entered the service in October, 1942, after having practiced in Waynesboro, Pa. for six years. He went overseas in September, 1943, and was stationed in New Ireland at the time of his death.

* * *

News about Akron physicians in the service . . . Lt. Comdr. Adrian Davis, orthopedic department, U. S. Naval Hospital, Shoemaker, Calif. . . . Major Paul Langan, chief of X-Ray, Dippoe General Hospital, Palto Alto . . . Major Arthur Dorner, chief of surgery, Merced Air Base, Calif. . . . Major Thayer Parry, eye section, O'Reilly General Hospital, Springfield, Mo. . . . Comdr. S. H. Black, U. S. Naval Hospital, Seattle . . . Capt. J. J. Scuderi, Army Air Base, Dyersburg, Tenn. . . . Major R. T. Allison and Capt. J. P. Goetz, met in a hospital ward in England . . . Capt. Harry Leuchtag and Lt. E. A. Kope, came together in a mess hall in New Guinea.

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CEREVIM IS VITAMIN FORTIFIED. A single one ounce serving exceeds the Board's recommendation for baby's daily requirement and provides all the Thiamine (B_1), Riboflavin (B_2), Niacin and Iron recommended for children up to three years of age. Substantial amounts of Calcium, Phosphorus and Pantothenic Acid are also supplied as "extra" factors.

*Reg. U.S. Pat. Off.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

ONE VITAL WAY TO HELP WIN THE WAR

On the cover page of this issue will be found a reproduction of one of the War Bonds which will be sold during the Fifth War Loan Campaign which will open on June 10.

Obviously, the reason for dedicating the cover of this issue to that topic was to encourage every Ohio physician and members of his family to invest as generously as possible in this 16 billion dollar War Loan program.

Doubtless, each physician on the home front has asked himself many times: "What is the most important thing I can do to help win the war?" Investment in the Fifth War Loan is the 16 billion dollar answer.

Individual investors are being asked to purchase bonds to the amount of six billions, at least.

The medical profession has made great sacrifices during the present emergency. But, it can and should make additional sacrifices. The needs and costs of the war must be met. Each physician can and should contribute more.

Enough said! Ohio physicians will do their part, we are confident.

YES, IT WAS A GOOD ANNUAL MEETING !

Despite conditions arising from the war, the Ninety-Eighth Annual Meeting of the Ohio State Medical Association, held at the Neil House, Columbus, on May 2, 3 and 4, was one of the most successful ever held by the Association.

Obviously, the attendance was smaller than that registered at most of the meetings held during recent years in Columbus as many of those who regularly attend the Annual Meeting are now in far-flung battle areas. However, the total registration of between 900 and 1,000 members and several hundred guests was an agreeable surprise to the Committee on Scientific Work and The Council which made and supervised the arrangements.

The Committee on Scientific Work deserves commendation for having arranged such an excellent program—a practical program. The Association is indebted to the out-of-state guest speakers and the Ohio speakers who sacrificed time and effort to appear before the general and section sessions. The addresses were on topics of current importance and ably presented. The informal Quiz-Discussion sessions again proved popular and exceedingly worthwhile, giving members a chance to get information and advice on cases and procedures which arise in everyday practice. The sessions of the Scientific Sections were well-attended and the presentations before the sections were carefully prepared and well-received.

Without doubt the Technical Exhibit was the best ever presented by the Association. Comments made by representatives of the various firms which exhibited attested to an unusual amount of interest on the part of those attending the meeting in the new products and equipment which were on display.

Because of the splendid assistance given by the members of the committees of the Columbus Academy of Medicine, all of the arrangements were carried out with a minimum of confusion. As usual, the management of the Neil House and the hotel staff cooperated 100 per cent which insured prompt and efficient service on all details.

The Association was pleased to have the Ohio State Radiological Society, the Ohio Society of Anesthetists, and the Ohio Chapter of the American College of Chest Physicians as a part of the meeting. It is hoped that these societies will continue to hold their annual sessions at the time of the Annual Meeting of the Ohio State Medical Association, as their programs will be a real asset to the State Association program if those of the future prove to be as good as those presented at the 1944 meeting.

Attendance at both meetings of the House of Delegates was large—unusually large. Questions of vital importance were considered and policies adopted. All members should read the minutes of both sessions of the House of Delegates, as well as the minutes of meetings of The Council, appearing elsewhere in this issue. Men of proven ability, experience and interest were selected as officers, Councilors and committeemen for the ensuing year, indicating that the affairs of the Association will be in capable hands during the turbulent months ahead.

In general the spirit of members who attended the Columbus meeting was good. All were tired, to be sure, as they have been carrying an enormous burden during the past several years. Yet, all displayed the traditional eagerness of the medical profession for new knowledge and indicated their willingness to make additional sacrifices in order to meet responsibilities on the home front and to fulfill the obligation which they owe to their colleagues who are with the fighting forces. Hysteria over existing problems and conditions vitally affecting medicine was con-



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spicuous by its absence. The dominating inclination was to face the facts and situations which have arisen in a calm, studious and deliberate manner; with courage, diplomacy and dignity. The general feeling appeared to coincide with the sentiments expressed by Dr. Sherburne, the retiring President, in his Presidential Address to the House of Delegates:

"In the end, many of the questions of vital concern to us will be settled in the court of public opinion. If we are logical in our arguments to the extent that we can show the public that it will be the loser if our advice and suggestions are ignored, we have nothing to fear. Our good intentions with respect to building up sound public relations and favorable public opinion can be ruined if we lose our heads, our dignity, our sense of balance and our self-respect by yielding to mass psychology. ***Change is not necessarily progress. Often change takes place through hasty action, unaccompanied by mature judgment. Progress usually is brought about through evolution, based on studious action."

Says the Cincinnati Post: "In our opinion (the term is not copyrighted) the medical societies would be doing a far greater service to the cause of prepaid medical care if they directed half of the energy now used in attacks on 'socialized medicine' legislation toward the constructive side of this social problem." Maybe so, but the socializers are not famous for their patience.

WE DON'T LIKE THIS KIND OF REGIMENTATION, EITHER

At the recent Annual Meeting of the Ohio State Medical Association in Columbus, the conversation in the halls and corridors frequently dealt with inquiries and debates about some of the new physicians' organizations which have been created to combat this or that, open an office here or there, publish bulletins on topics of medical economics, carry on public relations, etc.

Officially, the Ohio State Medical Association has neither approved nor condemned the formation of these organizations, leaving it to each member to decide for himself what he thinks of them; whether there is a need for them; whether he wishes to make a financial contribution to them.

The Ohio State Medical Journal, being the official publication of the Ohio State Medical Association, is obligated to abide by the official policies laid down by the House of Delegates and The Council. However, in our opinion, *The Journal* also is obligated to print facts and to ask questions which may assist members in passing judgment on questions which have to be decided by them as individuals.

One of the organizations which we have referred to above is the Association of American Physicians and Surgeons, founded by a group of physicians in Gary, Lake County, Indiana.

The founders of that organization are undoubtedly sincere, earnest and highly reputable physicians. But, in our opinion, their handiwork is something which should be studied and understood thoroughly by each physician before he affiliates with the organization.

For example, in joining the Association of American Physicians and Surgeons, the applicant is asked to make this pledge:

"The applicant shall further agree: (a) that where 75 per cent of the eligible physicians in civilian practice in the county where he practices have become members of the Association, he will not carry on professional relations nor cooperate with any non-member therein; (b) that he will not carry on such relations nor cooperate with a non-member physician in any other county where 75 per cent of the eligible physicians in civilian practice have become members; (c) that he will not carry on professional relations nor cooperate with any physician where such relations are deemed by the Association to be inimical to the interests of its members and those of the public; (d) that he will not carry on professional relations nor cooperate with any hospital or other institution where such relations are deemed by the Association to be inimical to the interests of its members and those of the public."

We wonder how many physicians who have "joined up" read that provision; knew about it; or fully understood its implications. There are a few other provisions in the By-Laws of the organization which are just as drastic.

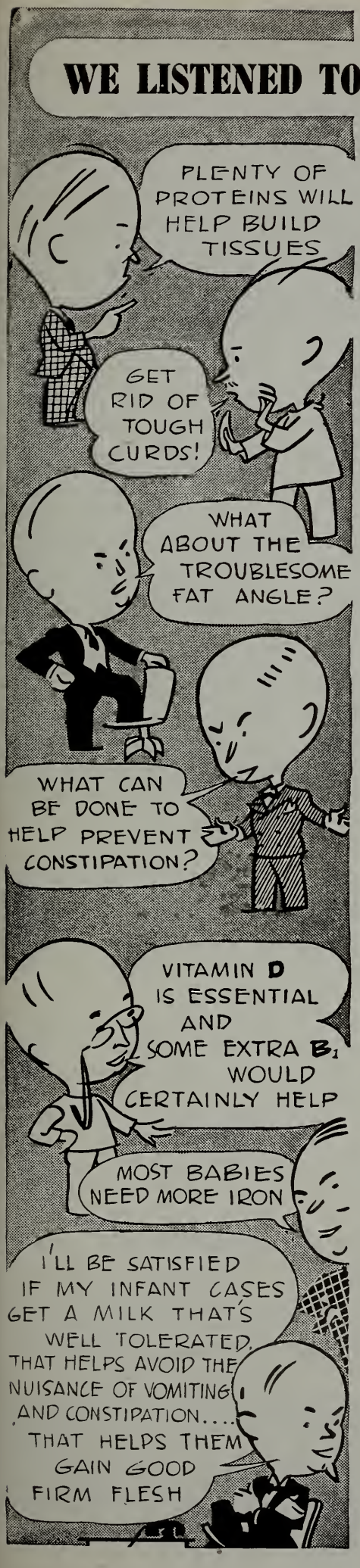
There is a lot to be said for the admonition that in fighting governmental bureaucracy we had better watch our step so as not to create a bureaucracy and regimentation of our own which will destroy us just as painfully and quickly as that established by government.

Moreover, in fighting governmental coercion, what is there to be gained by adopting coercive methods which would eliminate the very freedoms for which we stand?

Incidentally, the inference that a new organization can do more on legislation, public relations and medical economics than the American Medical Association can do is bunk, in our opinion. If those who want the A.M.A. to do more things than it is now doing would spend as much time and effort strengthening the A.M.A. through democratic procedures as they have spent in forming new organizations, there would not be even a flimsy excuse for a new organization.

In the final analysis, the medical profession is going to be judged by the court of public opinion. If the medical profession conducts itself in a manner which is acceptable to the public and for the best interests of the public, by-laws become

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unnecessary as the public is, and always will be, the supreme court.

The slogan of the Better Business Bureau is: "Before you invest, investigate". They have succeeded in convincing many people that this warning is a good one. Apparently a considerable number of physicians either haven't heard of this or are ignoring it.

TIMELY TRIBUTE PAID TO HOME-FRONT DOCTORS

Although they were seriously handicapped because of a shortage of newsprint and space, Columbus' three newspapers were exceedingly generous with the coverage which they gave to the recent Annual Meeting of the Ohio State Medical Association.

In our opinion, an editorial which was published in the *Columbus Dispatch* was especially timely. It paid a well-deserved tribute to physicians who have been carrying a heavy burden on the home front. Many tributes have been paid to Ohio physicians now with the armed forces, and rightfully so. At the same time, the fine work which older doctors and those ineligible for military service have been doing to fill the gaps must not be overlooked. The Dispatch's comments on this, reading as follows, pay proper recognition to the home-front physicians and offer some sound advice to the public with respect to current proposals to regiment medical and health services:

"The occasion of the Ohio State Medical Association's current meetings in Columbus is one which very aptly lends itself to some well-deserved attention to the state's doctors and the magnificent, tireless and vital work they are doing under extremely adverse circumstances.

"Many are the physicians who have been in retirement or who were about to retire who have come back into active practice or have redoubled their efforts to make up for the huge loss of physicians to the armed forces. Merely because a war is raging around the world, the people who must remain at home are in no less need of medical attention. In fact, in many instances, where mothers have doubled their own burdens by keeping house and at the same time have gone out to do war work, where older men have continued to work rather than quit in the midst of the nation's need or where they have gone back to the factories after having retired, where volunteer services in the hospitals and in other such necessary institutions have doubled up the load for middle-aged men and women, where the strain is heavier, where the hours are longer, where the work is more exacting and the time of leisure more limited, illness is more apt to appear than was the case before the war.

"The physicians, then, having had in practically every case to assume larger and larger loads. Someone once defined a superior man as one who was able to rise to his responsibilities. If that is the definition, then our doctors, practically without exception, have proved themselves to be superior men.

"They have faced not only the increase in the physical load demanded of them, but they have faced the emergency of an especially unfortunate manifestation of the new, socialized political conceptions which have been agitated by the war. The doctors, while conscientiously busy at their important tasks, giving of themselves and of their resources as never before, have had to face the threat of organized, subsidized and politically inspired administration of medicine. This threat has appeared in many forms, notably that of socialized medicine, but the threat is always the same, namely, the seizure of the physician's initiative, his prerogatives as a practitioner or specialist and regimentation under a government bureau which would dole out his education, dole out his practice, dole out his fees and lay out for him the manner of treating patients.

"The threat has made very little headway among informed people of the nation, but the collectivist idea, the socialized philosophy has appeared elsewhere in dangerous forms throughout the country and its menace to the doctors is one that is ever-present.

"It is not rooted in logic, but in prejudice. It is not aimed at humanitarianism but at political domination of another important field. The doctors fear it. And the doctors are battling it. But they have other, more pressing duties at the moment. Due to the call of duty and the necessity of filling the gap left by all their departed brothers, they cannot fight this subversive movement all alone.

"They have need of help. And the best kind of help they can have is the understanding of the public of their plight and a public resistance to the thing that would foist on them the same controls it is trying to foist on the rest of the nation through bureaucratic maneuvering and government control of every activity."

THOUSANDS HAVE BENEFITED THROUGH HIS GOOD WORKS

On June 30, Dr. Torald H. Sollmann will retire as dean of the Western Reserve University School of Medicine, a position which he has held since 1928.

Although Dean Sollmann will soon retire as a medical administrator, fortunately he plans to continue with his research in pharmacology for it is in this field that he has won international fame. Known as the "father of American phar-



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macology", Dr. Sollmann has made many outstanding contributions, all of which have played a leading part in making the modern treatment of the wounded and disabled one of the miracles of World War No. 2 and the present period truly the Golden Age of medicine.

From the beginning of his career at Western Reserve University almost 50 years ago, Dr. Sollmann's main interest has been pharmacology. One of his primary objectives was to improve teaching methods in that field so new crops of physicians would know more about the action of drugs and their administration, and thus be able to carry on their work with greater precision.

Dr. Sollmann has trained many men prominent in his field who have become heads of departments at other universities or research directors. His research in that subject was untiring. He has assembled a tremendous amount of information, both from his own extensive laboratory work and from the work of others into a monumental text entitled a "Manual of Pharmacology". This book, first published in 1917 and now in its sixth edition, is a standard text for medical schools and medical research organizations.

As a member and subsequently chairman of the Council of Pharmacy and Chemistry of the American Medical Association, he has consistently performed an important service to the people of the United States. The council has had an enormous influence on the suppression of patent medicines and quackery, and has been an important guide for doctors in the treatment of injury and disease. Dr. Sollmann has also performed important service to industry and the industrial worker as a consultant in industrial poisoning.

Ohio has been proud of its claim on Dr. Sollmann—educator, master in research, scholarly physician, and gentleman. His colleagues in Ohio and elsewhere long have regarded him as one of the elder statesmen of American Medicine. As he gives up administrative duties for activities which always have been so close to his heart, Dr. Sollmann will carry with him the sincere appreciation and best wishes of thousands who have learned from him and tens of thousands who have benefited through his good works.

REAL ANALYSIS OF PHYSICAL MEDICINE TO BE MADE

Bernard M. Baruch has established a fund of more than $1,000,000 to be used for teaching and research in physical medicine. A group of distinguished physicians and educators made an exhaustive survey of the field before the fund was established and an equally distinguished group will supervise the administration of the project. Grants will be made to a selected group of medical schools.

There is more than usual significance to this undertaking. During recent years, physical therapy has gained recognition as one of the important specialties in medicine. Unfortunately, however, teaching facilities have not kept pace with the need and demand for acceptable methods of treating disabilities by physical means. The Baruch funds will go far toward solving that problem.

However, the most significant factor is that now a job of thorough research can be done under well-controlled auspices in this field. Separation of the good from the bad, the scientific from the fallacious, the beneficial from the detrimental, will be one of the objectives of the supervisors. The ultimate result should be the elimination of fraud and quackery which has flourished in this field under the auspices, in most instances, of those without medical training. At the same time, it will encourage each physician to add proven and acceptable methods of treating the disabled through physical means to his armamentarium.

The outcome of this project will be watched with interest by the medical profession.

HOSPITAL PLANS SHOW IT CAN BE DONE

According to the Spring issue of the quarterly bulletin issued by the Blue Cross Plans of the United States and Canada:

Total membership in Blue Cross plans on January 1, 1944, exceeded 13,000,000 persons. Growth during 1943 numbered 2,600,000 persons.

Hospital payments by Plans annually exceed $60,000,000.

Plans, on the average, could provide several months of hospital care at current rates of utilization without additional income.

The average rate of hospital utilization for the year 1943 was 10.5 admissions per hundred participants. This is 3 per cent less than the 1942 average, and 2 per cent less than 1941.

The average length of hospital stay for Blue Cross patients for the year was 7.6 days as compared to 8.21 in 1942. This is less than the national average: the saving in manpower days amounted to 2,000,000 during 1943.

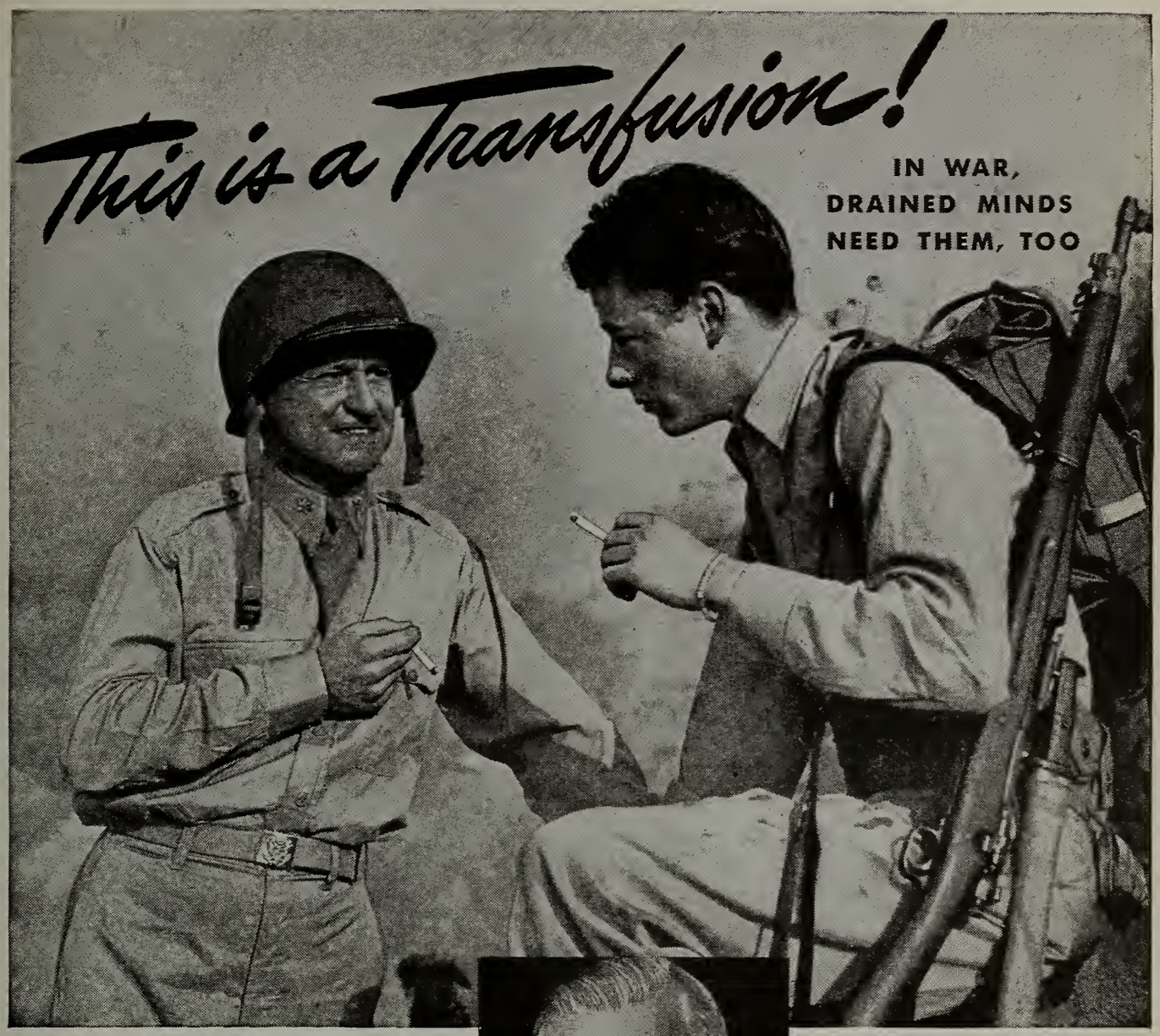
Blue Cross babies born in 1943 numbered 200,000.

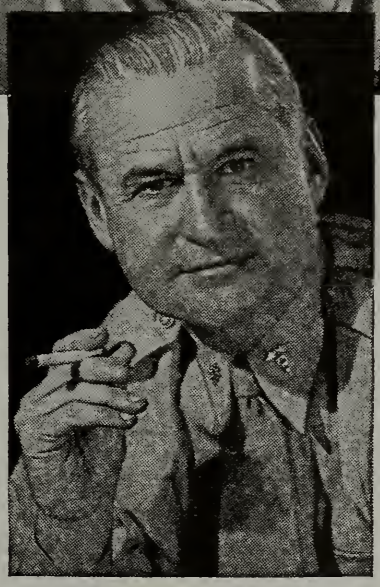
1944 Goal: at least 5,000,000 more subscribers.

Steady growth of the Blue Cross plans is proof that voluntary service programs can be operated successfully. Similar programs for distributing medical services can be made to operate just as successfully if the medical profession, with the cooperation of the public, will give them the proper push.

This is a Transfusion!

IN WAR, DRAINED MINDS NEED THEM, TOO





In modern war, fright, shock—no less than wounded flesh—sap fortitude, shrink staying power. Restoring fighters' morale is a constant concern of the military doctor. Whether under front-line fire or sheltered in a base hospital, he knows the lift of a friendly smile, a helping hand—a cheering talk over a cigarette. A Camel, most likely, the first choice of service men* for the real mildness and that deeply appreciated flavor.

It's a busy life for the medical officer... and a tough one. He too appreciates precious moments of relaxation... with a Camel.

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*With men in the Army, Navy, Marine Corps, and Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)



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New reprint available on cigarette research — Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

The Physician's Bookshelf

Food Resources of Africa, by Thomas S. Githens, M.D., and Carroll E. Wood, Jr., ($1.00, *University of Pennsylvania Press, Philadelphia, Pa.*) gives us important information about food production in this large and strategic continent. Thus the meager fat rations of Great Britain have come to depend largely upon the amount of ground-nuts, palm oil, and palm kernels that West Africa can furnish. The Middle-Eastern armies are likewise supplied with food from Eastern Africa. Therefore, it becomes of the greatest importance to know just what Africa's productivity is. This volume is a scholarly report of a thorough investigation of this continent.

Using Resources to Meet Food Needs, by Raymond P. Christensen, Agricultural Economist, Bureau of Agricultural Economics, U. S. Department of Agriculture, Washington, D. C., reports in detail on the relative deficiency of food products as sources of food. It is a book of reference that should be on the shelves of every physician who is interested in the food problem.

Experimental Chemistry, by George D. Wessinger, Ph.D., ($1.50, *Mosby, St. Louis)* presents a laboratory course in bio-chemistry for use where time is limited. For this reason, the book demonstrates by experiment only those facts which will give a good working knowledge of the subject. It is an excellent volume for any physician who finds it necessary to cram for an examination on a subject long-neglected or who, for some reason, has acquired a genuine interest in bio-chemistry.

Childbirth Without Fear, The Principles and Practice of Natural Child Birth, by Grantly Dick Read, M. D., ($1.75, *Harper & Brothers, New York City*) is addressed to expectant mothers as a word of encouragement. The author believes that childbirth is the most rewarding adventure possible to a woman and that she should be taught to look forward to it with joy. He insists that fear creates tension and tension, in turn, increases pain. By doing away with fear, through understanding and knowledge, childbirth becomes the natural, comparatively painless function that Nature intended it to be.

Food Enough, by John D. Black ($2.50, *Jaques Cattell Press, Lancaster, Pa.)* contains as good an analysis as has yet been published of the United States Food Conference at Hot Springs. Professor Black of Harvard tries to make us see the war in its totality and be willing to accept the hardships of producing food under wartime circumstances and handicaps. It attempts to answer the critics of our national food policy and takes particular pains to point out the frustration and confusion of our own Louis Bromfield and hundreds of thousands of similar farmers are of little consequence. He insists that an over-all view of the problems of production, of distribution and governmental control makes sense.

Food and War and the Future, by E. Parmarle Prentice ($2.50, *Harper & Brothers, New York City*) discusses the adequacy of the world's food supply in relation to increasing population. It thus reminds us of the relation of food needs to modern wars. Mr. Prentice speaks out of a lifelong knowledge of scientific agriculture. His "Hunger and History" will be recalled with pleasure, as well as his "Farming for Famine". When one recalls the statement of other authorities that it requires two and a half acres of arable land to support one human adequately and that there are only four billion available acres to support the two billions of people now living, one begins to looks anxiously at the limits of food land and the growing hosts of men. As Professor Morris has said, "Herein lies the roots of wars and the source of wisdom to found a true peace."

Introduction to Sociology and Social Problems, by Deborah Mac Lurg Jensen, M.A., ($3.25, *Second Edition, C. W. Mosby Co., St. Louis)* is, according to its author, a dual-purpose book being intended as a text for these two major subjects. Most of us will not have a chance to see this volume. We physicians are inclined to speak too glibly and disparagingly of social workers. Before we go off the deep end a couple of evenings spent with this volume might give us a clearer understanding of the viewpoint and objectives of this group who are so poorly understood by us.

Medical Genetics. A Series of Lectures Presented to the Medical Schools of Duke University, Lake Forest College, and the University of North Carolina, by Laurence H. Snyder, Sc.D. ($1.50, *Duke University Press, Durham, N. C.*) is a practical book designed to give help to the physician using modern genetics in his practice. It is really based on a course of lectures which have been given to the Sophomore Class in the College of Medicine of The Ohio State University for more than a decade. Part of the material has been published in this *Journal.* Following general principles and the medical-legal applications of hereditary traits, the various medical conditions are discussed system by system. It will be a great help to the physician in the prevention of inheritable diseases and abnormalities, in giving correct advice in prospective marriages and pregnancies and in determining the paternity of children in disputed cases.

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One level tablespoon of Similac powder added to *two* ounces of water makes *two* fluid ounces of Similac. This is the normal mixture and the caloric value is approximately 20 calories per fluid ounce.

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In Memoriam

Milton Homer Bachman, M.D., Youngstown; Jefferson Medical College of Philadelphia, 1906; aged 60; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Radiology; diplomate of the American Board of Radiology and the Radiological Society of North America; died April 14. Dr. Bachman had practiced in Youngstown since 1922. He was previously located in McKeesport, Pa. Dr. Bachman was a medical officer in the U. S. Army during World War I, serving two years in a base hospital in France. He was a member of the Elks Club and B'nai B'rith. Surviving are his widow, a brother and two sisters.

William McDowell Doughty, M.D., Cincinnati; Miami Medical College, Cincinnati, 1906; aged 63; member of the Ohio State Medical Association; Fellow of the American Medical Association, American College of Surgeons, American College of Radiology and the Radiological Society of North America; member and former president of the American Roentgen Ray Society; died April 18. Nationally known in the field of radiology, Dr. Doughty had practiced in Cincinnati for 38 years. A former president of the Cincinnati Academy of Medicine, he was director of radiology at Christ Hospital and senior radiologist at Children's Hospital. Dr. Doughty resigned as professor of radiology at the University of Cincinnati College of Medicine and assistant director of radiology at Cincinnati General Hospital in 1936 when he was appointed a director of the University of Cincinnati. A former member of the Committee on Workmen's Compensation of the Ohio State Medical Association, Dr. Doughty was a member of the Silicosis Board of the State Industrial Commission. He was a member of the American Association for the Advancement of Science, the Alpha Kappa Kappa fraternity, the Cincinnati University Club and Country Club and the Queen City Club. Two sisters survive.

Henry Kennon Dunham, M.D., Cincinnati; Miami Medical College, Cincinnati, 1894; aged 72; member of the Ohio State Medical Association; Fellow of the American Medical Association; diplomate, American Board of Radiology, American Board of Internal Medicine; member of the American Association for Thoracic Surgeons, American College of Physicians, American Clinical and Climatological Association, American Roentgen Ray Society, American College of Radiology and the Radiological Society of North America; died April 27. A leader in the fight against tuberculosis, Dr. Dunham practiced in Cincinnati for nearly 50 years. He was a founder and past-president of the Cincinnati Anti-Tuberculosis League, a past-president of the Ohio Public Health Association, and a past-president of the National Tuberculosis Association. His widow and a daughter survive.

Charles Tilden Hunt, M.D., Dayton; Miami Medical College, Cincinnati, 1906; aged 68; member of the Ohio State Medical Association and the American Medical Association; died April 28. Dr. Hunt went to Dayton from Miamisburg where he had practiced for many years. During World War I he served 18 months as a medical officer in the U. S. Army. Dr. Hunt was a member of the Methodist Church, Odd Fellows, Eagles, Masonic Order and the American Legion. His widow and a daughter survive.

Arthur Ralph Keirn, M.D., Dalton; Western Reserve University School of Medicine, 1932; aged 38; member of the Ohio State Medical Association and Fellow of the American Medical Association; died April 19. Dr. Keirn had practiced in Dalton and Wayne County for nearly ten years. He was a member of the local Board of Education, Community and Rotary clubs, Masonic Order and the United Presbyterian Church. Surviving are his widow, his parents, two sons and a daughter.

Max Mahrer, M.D., Cleveland; Western Reserve University School of Medicine, 1917; aged 52; member of the Ohio State Medical Association and Fellow of the American Medical Association; died May 3. Dr. Mahrer practiced in Cleveland for 23 years. Surviving are his widow, his mother, a son, a sister and a brother.

Grant B. Nichols, M.D., Wapakoneta; Medical College of Ohio, Cincinnati, 1883; aged 82; former member of the Ohio State Medical Association and the American Medical Association; died April 26. A native of Wapakoneta, Dr. Nichols began practice there with his father, and continued until his retirement several years ago. He is survived by his widow, a daughter, a sister and three sons, one of whom is Dr. J. H. Nichols, Cleveland, now a Lieut. Comdr. in the U. S. Navy at San Diego, Calif.

Edwards Hyndshaw Porter, M.D., Tiffin; Wayne University College of Medicine, Detroit, 1900; aged 71; member of the Ohio State Medical Association; Fellow of the American Medical Association, the American College of Surgeons and the American Academy of Ophthalmology and Oto-Laryngology; died May 14. Dr. Porter practiced in Tiffin for nearly 45 years, and was chief of staff of Mercy Hospital. During World



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War I, he was a medical officer in the U. S. Army. Well-known throughout the state, Dr. Porter was a former president and secretary of the Seneca County Medical Society, and had represented the society several times in the House of Delegates of the Ohio State Medical Association. A son and a daughter survive.

John Harrison Quayle, M.D., Cleveland; Cleveland University of Medicine and Surgery, 1895; aged 70; former member of the Ohio State Medical Association and the American Medical Association; died April 25, in Miami Beach, Fla. Dr. Quayle retired in 1934, after having practiced in Cleveland for 38 years. Active in community life, he was a charter member of the Cleveland Automobile Club, a life member of the Cleveland Chamber of Commerce, and chairman of the building committee which supervised construction of the Cleveland Athletic Club building. Surviving are his widow, two sons, a daughter and three sisters.

Edward Reinert, M.D., Columbus; Ohio Medical University, Columbus, 1897; aged 71; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American Radium Society; died April 30. Dr. Reinert practiced in Columbus for more than 45 years. During his earlier professional years, he was night physician at the Ohio State Penitentiary, and, later, surgeon to the Columbus police department and assistant superintendent of the city board of health. In 1918 he was appointed a member of the State Board of Administration by Governor James M. Cox. Dr. Reinert was the founder of Radium Hospital now known as Doctor's Hospital. He was a member of the Lutheran Church, the Elks Lodge and the Masonic Order. His widow and a son survive.

Rupert Reed Rogers, M.D., Warren; Columbia University College of Physicians and Surgeons, 1914; aged 57; former member of the Ohio State Medical Association, the American Medical Association and the American Academy of Pediatrics; died April 20. Dr. Rogers practiced in Warren for nearly 30 years, retiring 18 months ago because of ill health. He was a member of the staff of Warren City Hospital, a member of the local Rotary Club, Community Fund Board and Community Forum, and an elder in the Presbyterian Church. Surviving are his widow, two daughters, a son—Dr. Richard W. Rogers, Cleveland, and a sister.

Edward Isaac Stanley, M.D., Albany; Starling Medical College, Columbus, 1898; aged 69; member of the Ohio State Medical Association and Fellow of the American Medical Association; died May 9. Dr. Stanley practiced in Athens County for many years. Surviving are his widow, three daughters, a brother and two sisters.

COMING MEETINGS

American Medical Association, Chicago, June 12-16.

American Association for the Surgery of Trauma, Chicago, June 9-10.

American Association of Genito-Urinary Surgeons, Stockbridge, Mass., June 8-10.

American Broncho-Esophagological Association, New York, June 6.

American College of Allergists, Chicago, June 10-11.

American College of Chest Physicians, Chicago, June 10-12.

American College of Radiology, Chicago, June 14.

American Diabetes Association, Chicago, June 11.

American Federation for Clinical Research, Chicago, June 12-13.

American Gastro-Enterological Association, Chicago, June 12-13.

American Gynecological Society, Hershey, Pa., June 19-21.

American Laryngological Association, New York, June 7-8.

American Laryngological, Rhinological and Otological Society, New York, June 9-10.

American Medical Women's Association, Chicago, June 10-11.

American Physicians' Art Association, Chicago, June 12-16.

American Proctologic Society, Chicago, June 11-15.

American Therapeutic Society, Chicago, June 10.

American Urological Association, St. Louis, June 19-22.

Association for Research in Ophthalmology, Chicago, June 13.

Association for Study of Internal Secretions, Chicago, June 12-13.

Ohio Public Health Association, Columbus, June 7-8.

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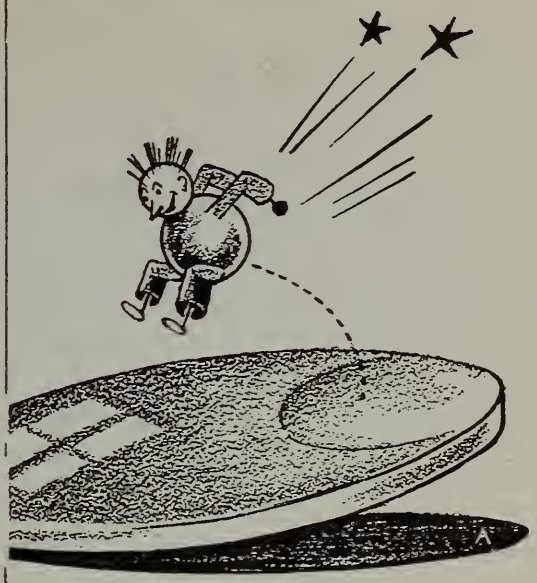
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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

CLINTON

Dr. Richard Bath, Wilmington, spoke on "Physiology of Sex Hormones", at a well-attended meeting of the Clinton County Medical Society, May 2, at the General Denver Hotel, Wilmington.—R. W. DeCrow, M.D., secretary.

HAMILTON

At a meeting of the Cincinnati Academy of Medicine, May 16, in the Union Central Annex Auditorium, Dr. David W. Heusinkveld spoke on "The Vanishing Lung", and Dr. William A. Altmeier discussed "Penicillin in Surgery".—Bulletin.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

MIAMI

The program for a meeting of the Miami County Medical Society, May 12, at Stouder Hospital, Troy, consisted of a motion picture, "Caudal Anesthesia in Obstetrics", through the courtesy of the Eli Lilly Company; an address by Dr. W. A. Ricketts, Dayton, on "Bleeding in the Last Trimester of Pregnancy"; and a report on the recent Annual Meeting of the Ohio State Medical Association by Dr. G. A. Woodhouse, delegate from the society.—G. A. Woodhouse, M.D., secretary.

MONTGOMERY

"Diverticulitis of the Colon", was the topic discussed by Dr. Paul Shank at a meeting of the Montgomery County Medical Society, May 5, at Dayton.—Don Padan, M.D., president.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOELDO)

LUCAS

The Academy of Medicine of Toledo presented the following programs during May:

May 12—Section of Pathology, Experimental Medicine and Bacteriology. "X-Ray Aspects of Cardiovascular Diseases", Dr. Fred J. Hodges, professor of roentgenology, University of Michigan Medical School, Ann Arbor.

May 19—Medical Section. "Symposium on Hypoglycemia", by Drs. L. F. Smead, J. L. Stifel, H. H. Heath, L. A. Levison and G. W. Bascom.

May 26—Surgical Section. "Caesarean Section—Types", Dr. M. W. Diethelm; "Indications and Contra-Indications", Dr. D. S. Booth.—Bulletin.

Fifth District

(COUNCILOR: FRED W. DIXON, CLEVELAND)

CUYAHOGA

The following programs were presented by the Academy of Medicine of Cleveland during May:

May 5—Clinical and Pathological Section. "Cervical Teratoma in the New Born—Case Report", Dr. R. J. Frackelton; "Chronic Tetanus—Case Report", Dr. Charles S. Stone; "The Management of Jejunal Ulcer—Case Report", Dr. R. John F. Renshaw; "An Injection Study of Uterine Blood Vessels", Dr. Robert L. Faulkner; "Lacuna Skull—Case Report", Dr. E. von Baeyer; "Cushing Syndrome Due to Adrenal Tumor in a Child of 18 Months", Dr. R. W. Schneider.

May 19 — Annual Academy Meeting—"The Pathology of Murder", Dr. Alan Richard Moritz, professor of legal medicine, Harvard University Medical School.—Bulletin.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

MAHONING

Dr. Merrill F. Steele, superintendent of Christ Hospital, Cincinnati, spoke on "Some Present and Post-War Hospital Problems", at a meeting of the Mahoning County Medical Society, May 16, at the Youngstown Club.—Bulletin.

PORTAGE

Dr. H. K. Giffen, Cleveland, spoke on "Some Problems in Tropical Diseases", at a meeting of the Portage County Medical Society, May 11, at the Robinson Memorial Hospital, Ravenna.—Emily Widdecombe, M.D., secretary.

SUMMIT

Dr. Roger E Heering, chief of the venereal disease unit, State Department of Health, spoke on "Venereal Disease Control in Ohio", at a meeting of the Summit County Medical Society, May 9, at City Hospital, Akron.—Bulletin.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

COSHOCTON—TUSCARAWAS

An interesting address on post-war medical treatment of returning servicemen was given by Major Altschuler of Fletcher General Hospital, Cambridge, at a joint meeting of the Coshocton and Tuscarawas County Medical Societies, April 20, at Newcomerstown.—News clipping.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

LICKING

Members of the Licking County Medical Society were guests of the Owens-Corning Fiber-

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GYNECOLOGY—Two Weeks Intensive Course starting October 2. One Week Personal Course Vaginal Approach to Pelvic Surgery starting October 23.
OBSTETRICS—Two Weeks Intensive Course starting June 26.
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glass Company at a meeting, April 25, at the Granville Inn, Granville. Thomas Durkan, head of the Saranac Laboratories, Saranac Lake, N.Y., was the guest speaker.—News clipping.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

SCIOTO

At a meeting of the Hempstead Academy of Medicine, May 8, at Portsmouth, Miss Thelma B. Ward, superintendent of Portsmouth General Hospital, outlined the plan by which penicillin is to be distributed in the area. Portsmouth General Hospital is to serve as the dispensing headquarters. An advisory committee of four local physicians, one from Mercy and General hospitals, one from the Academy and the local pathologist, was established to determine that allocations of the drug be made in conformity with the proper criteria indications outlined in instructions issued by the War Production Board.—Thomas W. Frame, M.D., secretary.

Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

FRANKLIN

Dr. Myron D. Miller spoke on "Newer Aids in the Diagnosis and Treatment of Tuberculosis", at a meeting of the Columbus Academy of Medicine, May 15, at the Franklin County Tuberculosis Hospital.—Bulletin.

KNOX

Dr. John W. Means and Dr. Joseph DeLor, Columbus, spoke on "Diagnosis and Management of Diseases of the Liver", at a meeting of the Knox County Medical Society, April 27, at Mt. Vernon.—F. C. Anderson, M.D., secretary.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

ASHLAND

A motion picture demonstrating the use of the Rankin clamp in the resection of a malignancy of the transverse colon, was shown at a meeting of the Ashland County Medical Society, April 21, at Ashland.—Reid P. Joyce, M. D., Ashland.

MEDINA

Local dentists, druggists, nurses and members of hospital boards were guests at a meeting of the Medina County Medical Society, April 20, at the Evanon, on Route 3, east of Medina. Dr. Robert M. Hosler, Cleveland, spoke on "The Wagner-Murray-Dingell Bill". Congratulatory remarks were made by various members of the society to Dr. Harry Streett, who has been practicing medicine for 50 years, the past 44 in Litchfield.—E. L. Crum, M.D., secretary.

LORAIN

Dr. Geo. H. Irvin, Cleveland, spoke on "Practical Endocrine Therapy in the Female", at a meeting of the Lorain County Medical Society, May 9, at the Lorain Country Club.—L. H. Trufant, M.D., secretary.

WAYNE

Members of the Wayne County Medical Society were guests of Dr. A. T. Hopwood at the State Institution for the Feeble-Minded at Apple Creek, April 19. Dr. Hopwood, superintendent of the institution, gave a very interesting talk on the type of patients and their treatment.—R. C. Paul, M.D., secretary.

WOMAN'S AUXILIARY NEWS

FRANKLIN

The Second Civic Housekeeping Institute of the Woman's Auxiliary to the Columbus Academy of Medicine was held at the Deshler-Wallick Hotel, April 7. Speakers included: "The Program of the State Department of Health", Dr. Roger E. Heering, chief, venereal disease unit, State Department of Health; "The Maternal and Child Health Program of the U.S. Children's Bureau as it is Operating in Ohio", Dr. Susan Souther, director of maternal and child health, State Department of Health; "The Ohio Department of Agriculture Program to Protect the Food Supply of Ohio", Mrs. Lottie M. Randolph, assistant director of agriculture; "The Columbus Department of Health—the Protector of Community Health", J. Herbert Mumm, secretary of the Columbus Board of Health; "Columbus Water Supply", Clarence Hoover, superintendent of the Columbus Water Department; "Columbus Meat and Milk Supply", J. H. Draper, milk analyst, Columbus Department of Health.

MAHONING

A dramatization of a popular play by Mrs. Sidney Moyer, Mrs. Martha A. McAlpine and Mr. Talbot Pearson of the Youngstown Players, featured a meeting of the Woman's Auxiliary to the Mahoning County Medical Society, April 17, at the home of Mrs. W. O. Mermis, Youngstown. Mrs. R. B. Poling and Mrs. Earl Brant presided at the tea table. Mrs. Waldo Z. Baker and Mrs. James B. Nelson assisted Mrs. Mermis.

STARK

Mrs. Kenneth Greenwalt was named president-elect of the Woman's Auxiliary to the Stark County Medical Society, when the group met April 18, at the Canton Woman's Club. Mrs. James H. Bahrenburg will take office as president when the Auxiliary meets again on June 13.

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Other officers are: Mrs. Harold Bowman, vice-president; Mrs. Robert Graham, recording secretary; Mrs. Emerson Gillespie, corresponding secretary, and Mrs. Joseph Toot, treasurer. Annual reports were presented at the meeting, at which the retiring president, Mrs. L. L. Frick, presided. Chairman of the meeting was Mrs. L. H. Werley, and a report on Red Cross activities was made by Mrs. C. O. Paradis. Dessert was served to more than 50 members at tables attractively arranged with seasonal flowers. Mrs. C. B. King is chairman in charge of the June 13 meeting and picnic.

TUSCARAWAS

Mrs. Edna Straub, Dover city health nurse, explained the Kenny method for the treatment of infantile paralysis at a meeting of the Woman's Auxiliary to the Tuscarawas County Medical Society, April 13, at the home of Mrs. Burrell Russell, New Philadelphia.

WASHINGTON

The Woman's Auxiliary to the Washington County Medical Society met at the Betsey Mills Club, Marietta, April 12, with Mrs. I. J. Johnson as hostess. Mrs. Annie L. McKinnon presented a review of "Our Hearts Were Young and Gay", by Cornelia Otis Skinner and Ellen Kimbrough. It was announced that the time which individual members have spent in community and war work, such as Red Cross and in the hospital, in the past year, has reached a total of 1,043 hours. Mrs. E. W. Hill, Jr., reported that the refund from the collection of sales tax stamps from the Fall of 1943 to March 1, 1944, has netted $243 for Memorial Hospital.

Columbus—Dr. Paul H. Charlton has been appointed acting medical director of the Ohio State Life Insurance Company. He will attend to the medical phases of underwriting in the absence of Dr. Thomas F. Ross, now a Lieut. Comdr. in the U. S. Navy.

Cincinnati—Dr. K. W. Ascher was a guest speaker at the recent meeting of the St. Louis Ophthalmologic Society. He discussed recent observations on aqueous veins, the newly detected biomicroscopically visible connections between the canal of Schlemm and the anterior ciliary veins.

Logan—Cherrington Hospital, operated by Drs. J. S. and M. H. Cherrington for 36 years, closed on May 15.

Marion—Over 200 persons attended a community-wide party and dinner at nearby Kirkpatrick honoring Dr. C. L. Baker on the 50th anniversary of his entrance into the practice of medicine there.

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Vol. 40 July, 1944 No. 7

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.* GEORGE H. SAVILLE, *News Editor*

Some Phases of the Prevention Program for Poison Ivy Dermatitis*

LEON GOLDMAN, M.D.

THE treatment of poison ivy dermatitis at the present time is still largely, if not entirely, symptomatic. Save for improvement in the comfort of the patient and in the prevention of secondary infection, the course of the primary dermatitis is altered scarcely. The individual starts with a mild, moderate or severe episode. In spite of the popularity of specific antigen for treatment, relatively few carefully controlled studies of this form of therapy have been done, and moreover, this form of treatment[1,2] has been shown to be dangerous during the actual course of a poison ivy dermatitis. So, at the present time, the real problem in the control of poison ivy is prevention. Such prevention is entirely practicable and may be considered logically in the following phases:

1. Removal of the plant.
2. Prevention of contact of the individual with the plant.
3. Removal of plant material from cutaneous surfaces after contact.
4. Attempts to render the individual less susceptible to contact.

Practically every agricultural experimental station in the country is interested in the destruction of the poison ivy plant. The United States Department of Agriculture has been active in the study of poison ivy control chiefly through the interest of L. W. Kephart,[3] Senior Agronomist, in charge of Noxious Weed Investigations of the Bureau of Plant Industry of the Department of Agriculture. A bulletin on the control of poison ivy is available from this Bureau. Many of the chemical materials for the destruction of the plant are not available at present but in the postwar period many new and highly effective and selective substances will be used. At the present time such mechanical measures for removal of the plant as grubbing, cutting, plowing, all by relatively resistant individuals, the local use of borax, strong salt solutions, kerosene, can be and should be done early in the Spring. For susceptible individuals even the roots are highly irritant and this has been shown by episodes of poison ivy dermatitis among road construction workers during the Winter time. However, because of the widespread distribution of the plant a great deal more than individual attempts in one's own surroundings are needed. A community or area control program is required.

*From the Department of Dermatology and Syphilology of the College of Medicine of the University of Cincinnati. Member of the Committee for the Cooperative Clinical Study of Poison Ivy Desensitization.

The Author

● Dr. Goldman, Cincinnati, Ohio, is a graduate of the University of Cincinnati College of Medicine, 1929; fellow, American Academy of Dermatology and Syphilology; member, Society for Investigative Dermatology and Committee for the Cooperative Clinical Study of Poison Ivy Desenitization; diplomate, American Board of Dermatology and Syphilology; assistant professor of Dermatology and Syphilology, College of Medicine, University of Cincinnati.

THE GLENDALE PLAN OF POISON IVY CONTROL

A practical community program may be considered from an analysis of the Glendale Plan of Poison Ivy Control. Glendale is a suburban village north of Cincinnati and has a population of 2,400 with a well organized and very active

community life. In 1941 a plan of poison ivy control was organized chiefly through the efforts of Mrs. Robert F. Lovett[4] and her associates. This plan had the following phases:

1. Mapping of the heavily infested areas throughout the entire village.
2. The uprooting and destruction of the plant in early Spring.
3. An education program, against the poison plant, which included: a. active interest and cooperation of the Garden Club; b. educational program at the school; c. display literature with posters made by school children and printed dodgers.
4. The enactment of a weed ordinance requiring the removal of poison ivy from the premises.

Such is a brief outline of this particular community's program. The medical aspects of the program, that is, the attempts at immunization of known susceptible individuals and advice for the removal of poison ivy from the skin were not considered in great detail in the first year of this program. At the end of the 1941 season it was felt that definite results had been accomplished and that the program should be continued again in 1942 with special emphasis on the educational phase.

One difficulty which had begun to be felt first in 1942 and then in 1943 was the lack of manpower to clean out the weeds. This lack of help threw the burden on the home owners themselves and consequently was much less successful for community control than a centralized poison ivy eradication group developed by the village council itself. So, it was felt that for the last two years, control has been not as effective because of the lack of manpower, and also in 1943, because of the lack of suitable chemicals for the plant destruction.

Chiefly through the efforts of the garden clubs in the adjacent communities and in Cincinnati itself, considerable interest was stimulated in poison ivy prevention. Large exhibits were arranged by the garden clubs and also some medical aspects were included, such as the advice for known susceptible individuals to see their physicians early in the Spring, also simple suggestions were given for the removal of poison ivy from the skin after contact and simple instructions were given on the initial care of a poison ivy dermatitis. It was felt that such educational programs had been of value and would be continued in much greater detail in the postwar period. When each community institutes control measures or when control is done over large areas, then the results will be so much more effective.

THE PREVENTION OF CONTACT OF THE INDIVIDUAL WITH THE PLANT

The practical program here is essentially protecting the cutaneous surface from direct contact with the plant. Although from work[5] with oral antigens it has been found that individuals can get a vesicular dermatitis from ingestion alone, from a practical aspect, the protection of the cutaneous surface only should be enough.

The simplest type of protection is by the use of clothing, such as shoes or boots and a heavy type of cloth through which the oleoresin material from the plants can not soak. Care should be taken in removal of this clothing, especially shoes, since the outside of the shoes, gloves, slacks, etc., are contaminated and hands should be washed very thoroughly after taking off such clothes. It is not known at the present time how long such contaminated clothing is active but at least from clinical histories which are, of course, of doubtful value as regards actual contact, clothing may be a factor even as long as twenty-four hours later. Garden tools, of course, may also become contaminated. Animal skin and hair can be contaminated also.

To provide a more convenient form of protection the use of protective creams has been suggested ever since the work of Schwartz, Warren and Goldman,[6] on this. For effective cutaneous protection, the same general objections to the use of protective creams may be found in prevention of poison ivy dermatitis as in almost any type of industrial dermatitis where protective creams are used. These general objections include such factors as the tendency to place too much emphasis in the protective cream factor and not in other control measures, breaks in the surface of the protective barrier, no prevention of heat insulation, etc. In addition, there is a real doubt as to whether these protective materials, creams, liquids, soaps, etc., work. The following substances have been considered for protective agents against poison ivy:

1. Detergents—especially strong soaps.
2. Alcohol.
3. Kerosene.
4. Ferric chloride.
5. Potassium permanganate.
6. Sodium perborate.
7. Zinc peroxide.
8. Urea peroxide.
9. Sodium hydroxide in glycerin water mixtures.

Howell[7] has recently described the difficulties of attempting to evaluate critically the degree of cutaneous exposure to poison ivy oleoresin. To answer some of these objections as to the intensity of contact with the skin and to the variations in the potency of poison ivy extract, he has suggested the use of finger test with the oleoresin obtained from fresh green leaves. This resinous material, on the fingers of relatively resistant individuals, is rubbed on the volunteer's skin.

As has been mentioned so often before, there is still a lack of standardization of poison ivy extracts. Bailey[8] is reported to have devised a

method of chemical standardization that is reported to be accurate within a range of 5 per cent. Stratton[9] has suggested a biological method of standardization. Although there may be also variation of the skin irritation quality of the various plants oleoresinous materials, nevertheless, this finger test of Shelmire and Howell[7] seems most reliable under present circumstances. With this technic, Howell[7] has believed that soap and water white petrolatum, 10 per cent ferric chloride ointment, or 10 per cent sodium perborate ointment did not prevent posion ivy dermatitis in susceptible individuals. He claimed that a solution of 10 per cent potassium permanganate "prevented or diminished the severity of ivy dermatitis in most instances if employed during the first fifteen minutes after exposure".

We have been working with zinc and urea peroxides in the form of stable ointment mixtures, as recommended by Altemeier.[10] With artificial contact testing, and no field controls, some protective value seems assured if the peroxides are applied early. Moreover, these ointments may be used when a dermatitis actually occurs because the mixtures are non-irritating to the skin, relieve pruritus and do prevent secondary infection which may result from scratching. Hydroxide, glycerin water mixtures recommended originally for lacquer dermatitis were tried also. These strongly alkali mixtures were too irritating for general use although there was slight protective value. Allied closely to the prevention of actual contact with the cutaneous surface is the attempted removal of the oleoresin after contact. Some features of this have been mentioned above.

REMOVAL OF THE PLANT MATERIAL FROM THE CUTANEOUS SURFACE AFTER CONTACT

When the sticky oleoresinous material from the poison ivy plant does get in the skin, certain preventive measures are still possible. The factor of speed has been suggested above and this should be emphasized again because obviously it is much easier to remove substances which are on the skin surface than materials which have been absorbed through the skin and may be found deep in the pilosebaceous apparatus and in other gland structures or even in the papillae. Such penetration experiments have not been done as yet with the poison ivy but have been done with other materials which cause contact dermatitis, and the same general principles should follow.

Some factors which may control the depth of penetration of the poison ivy antigen are solubility in skin lipids, lack of chemical reactive substances in the cutaneous barrier, suitable pH, increased activity of the skin in the Summer, etc. One usually waits until the end of the day or at least some hours after the supposed contact to do prophylaxis and then one is disappointed when such schemes do not work.

The materials which are available for removing oleoresins from the skin are, of course, the detergents and the organic solvents. If the contact area is known, the careful use of these, especially the organic solvents, may remove an appreciable amount of the sticky oleoresin (from the skin) but when the contact area is not known, the careless use of these materials will succeed in spreading agent over the skin. Contrary to the experiments of Shelmire and Howell, it has been our experience that the use of the organic solvent within ten to fifteen minutes will prevent the artificial production of poison ivy dermatitis in sensitive individuals. We did not use the finger test.

With the newer development of materials which will penetrate deeply into the skin there will be available, we hope, a vehicle for incorporating these substances which can react definitely with the poison ivy oleoresin and these mixtures may be able to be applied even after contact, perhaps, even until the development of the antigen-antibody reaction. From a practical or perhaps only psychological standpoint, however, the protective mixture may be advised, if it is used shortly after contact and if the area of contact is known. The protective mixture should be rubbed in well, then later washed and rinsed from the skin.

ATTEMPTS TO RENDER INDIVIDUALS LESS SUSCEPTIBLE TO CONTACT

This last phase of the prevention program has become of interest now chiefly through the recent work of Shelmire[12] with oral antigens. Clarke[11] reported that as early as 1820 a Dr. Dakan of New Jersey suggested oral therapy for poison ivy. Of those[5] associated with the early development of specific prophylaxis against poison ivy are included Attix, French, Duncan, Schamberg, Strickler, Spain and Cooke. The following methods are available today for attempts at desensitization or hyposensitization of poison ivy sensitive individuals:

1. Injection—parenteral use of extract in oil or alcohol vehicles.
2. Oral methods with extract in: a. tincture, b. capsules, c. tablets.
3. Cutaneous application of poison extract.

In truly sensitive individuals who are followed over a period of years the injection of poison ivy extract is without any great prophylactic value. It has been difficult to evaluate results because susceptibility to poison ivy is so little understood and so confusing in spite of graded patch testing series. Results, therefore, will be hopelessly puzzling unless susceptible individuals are studied. It is not well known[1,2]

that uticaria and even angioneurotic oedema and pruritus ani have been reported following injections of poison ivy extract. It is because of the failure of the injection methods that the oral antigens were studied again by Shelmire[12] and reported since 1938.

Attempts at protection by applications of diluted antigen directly to the skin have been made.[13] One method has been the addition of antigen to bath water. My initial attempts with this were unsuccessful in securing protection. There have been no further reports on this in the literature.

Through the efforts of Sulzberger[14] and Shelmire and "at the instigation of special committees of the American Medical Association, the American Dermatological Association and the Society of Investigative Dermatology, and with the collaboration of Lederle Laboratories, about 30 representative dermatologists throughout the United States undertook a group experiment in which several hundred known poison-ivy-sensitive patients were treated prophylactically by the method of oral desensitization".

The method studied was the oral method of Shelmire which has been reported previously. It was felt that most available tinctures were too weak to provide any effective prophylaxis, even if continued over long periods of time. In very susceptible individuals the use of even the weak tincture may be dangerous in that dermatitis of the face may be produced from the careless use of this, as in children, and even the rare cheilitis and stomatitis venenata.

The oral extract studied by the Committee was a potent one in corn oil, and for the average case was used diluted, 1:25. Shelmire's clinical standard for an oral antigen was one that "must cause a positive reaction on the back of a person of average sensitivity when diluted at least 2,500 times with corn oil and applied in a patch test". He estimated, "the ingestion of approximately 2 CC of a stable and potent ivy leaf oil is necessary to reduce the cutaneous sensitivity of the average person from clinical to subclinical level".

Because of the high percentage of cutaneous reactions most of the patients under this study, did not continue the medication. The conclusions reported by Sulzberger[14] were that, "The results reported by this group were inconclusive, both on the basis of pre- and post-treatment patch testing of clinical protection. While many persons seem to acquire some protection, many others did not. Moreover, some patients could or would not complete their courses of drops. The disagreeable by-effects noted included pruritus ani and vulvae, dermatitis of the hands and other parts, burning of the mouth, heartburn, general malaise, flare-ups of old clinical or patch test poison ivy sites, etc. Unfortunately, the method seems to require much further study, modification and improvement before it can be considered of general practical value."

My report to this Committee, however, was favorable. The relatively few individuals, and those indeed were a hardy group of highly susceptible and selected volunteers, who continued to be my patients after the initial cutaneous reactions occurred, did show excellent results. When they took the required dosage of antigen, they did show significant changes in pre- and post-treatment patch testing and definite clinical protection. My objections, too, were of course the high percentage of cutaneous reactions, 89 per cent when the initial treatment was begun with relatively large doses and 28 per cent when it was begun with small doses. In none of the cases, except for pruritus ani in certain adults, were the reactions in any way comparable to the severe episodes of poison ivy dermatitis which these individuals were accustomed to have.

In certain individuals, pruritus ani may continue for some time after the discontinuance of the oral antigen. An effort was made to determine whether there were any local features which might predispose to the disturbing reaction of pruritus ani. Seven cases of pruritus ani following the use of oral antigen were studied. These cases included, two in children and five in adults. Three had had original poison ivy dermatitis in the perianal area, two, one year previously, one, three years previously. All seven developed the pruritus ani early in the course of therapy.

In the children, the reaction was simply pruritus without dermatitis and this reaction subsided rapidly, within three or four days, after the antigen had been stopped and did not recur when the antigen had to be started again. Two adults had dermatitis associated, one a severe vesicular dermatitis of the vulvae also. Two adults had local conditions associated, one rectal polyps, the other a small fissure. Two individuals continued to have pruritus ani for three to four weeks after the antigen was discontinued. One of these had the dermatitis of the vulvae and developed psychosomatic reactions about the vulvae and rectum. The other patient was the one with the fissures and he also had had poison ivy dermatitis about the perianal area the year before.

In regard to the complication of pruritus ani of oral antigen therapy, the dosage should be less and the increase should be very gradual in those individuals who have had actual episodes of poison ivy dermatitis about the rectum and genitalia. Similar precautions should be adapted for those with known rectal pathology, either structural or psychosomatic.

It is possible also that instructions in regard to careful hygiene after the bowel movement may be of some prophylactic value. When the

pruritus ani occurs, oral antigen should be discontinued as a rule, and bland therapy such as the heavy calamine pastes, compresses, Sitz baths, etc., used. In regard to further antigen therapy in these individuals one must consider the wishes of the patient and your own appraisal of his pathology and his personality pattern.

Another objection, although a minor one, was the inconvenience of using a capsule in which drops had to be placed, so they would not spill, and then to close the capsule and finally swallow it. The cooperation of parents was necessary for its use in children and even susceptible adults were not anxious to fill their own capsules for fear of spilling some of the extract. I tried capsules containing "unstandardized amounts of dried poison ivy extracts"[5] with, however, poor clinical protection.

Although Spain and Cooke[5] described a poison ivy tablet in 1927, which had produced favorable results, it is only in the past few years that such tablets have been studied extensively. Zisserman[15] in 1941 used enteric coated tablets containing a very small dose and Gold and Masucci[16,17] used tablets containing larger doses of oleoresin. These latter investigators reported success. Their main objections were the relatively high percentage of reactions and the fact that the "skin desensitization that results from oral therapy against poison ivy is not of long duration, lasting in some patients only a few months".

Impressed with the fact that oral antigen therapy in adequate dosage does offer protection against poison ivy dermatitis, I attempted to determine whether such protection could be maintained when efforts were made to reduce the all too high frequency of reactions. Dr. Arthur F. Coca[18] of Lederle Laboratories supplied the poison ivy by oleoresin (1:25) in tablet form with concentrations varying according to the color of the tablet:

Brown	1 drop	of 1:100
Blue	1 drop	of 1:50
Green	1 drop	of 1:25
Red	2 drops	of 1:25

The following dosage schedule was suggested by Dr. Coca and was modified only for the very susceptible individuals or for those with reactions. The tablets were taken one after a meal once a day.

First week	1 brown daily
Second week	1 blue daily
Third week	1 brown and 1 blue daily
Fourth week	1 green daily
Fifth week	1 red daily
Sixth week	1 green and 1 red daily
Seventh week	2 red daily

With this dosage then, approximately 2 cc. of the oil (1:25) is taken over a period of seven weeks. However, this total dosage is too small according to Shelmire's standard and does explain the results obtained below.

A group of 30 susceptible individuals, adults and children, were selected for the study of the effect of these tablets. Most of the individuals had been volunteers in previous protective studies and graciously and courageously consented to continue with "another and new remedy". No pre- or post-treatment patch testing was done and no control field studies were made. Since these were a highly selected group of very susceptible individuals many of whom had been followed now over a period of four years, it was felt that their own critical opinions were good even for crude analysis. Moreover, the past season, 1943, was accepted as a "good poison ivy season" because of the heavy rains and the general incidence of poison ivy dermatitis in clinics and private practice seemed heavier than usual. Of the 30 who took the pills, follow-up surveys were possible on 28. Most of the dosage schedules were finished in May or June. Of the 28 patients reactions occurred in seven:

Pruritus generalized and mild—1.

Pruritus ani—2, one individual had rectal polyps and one a fissure.

Blotchy erythema—3, usually on the face or upper extremities, transient.

Vesicular dermatitis—1, individual became confused with dosage schedule and took practically all the pills in one week.

The reactions then totaled approximately 25 per cent. Practically all the patients had what for them was good exposure to the plant. Of the 28 patients five had severe episodes of poison ivy dermatitis during the season and four had very mild episodes. Although mild episodes should not be considered as absolute failures, yet they will be included here and so approximately 32 per cent had a poison ivy dermatitis. Of those five severe episodes, three patients in one susceptible family group took only one-half of the required number of tablets and then stopped because they were not interested in continuing. In the latter part of the Summer all three had severe poison ivy dermatitis.

Another patient of this group of five distinct failures was sensitive to the pills and he did not wish to continue them. He developed repeated episodes of poison ivy dermatitis even into October. For this patient in the past year it was also impossible to prevent his poison ivy dermatitis with small amounts of the corn oil antigen capsules. Since he, too, had inadequate dosage, then there was only one true failure. Of the four patients who had mild episodes, all save one had completed the dosage schedule. It is also interesting to note that three of the "mild" failures occurred only in September and the course of the pills had been completed in May. In the survey conducted at the end of the

season all these patients indicated a desire to try again next year. The conclusions then from the use of the protective tablets in a group of highly susceptible individuals were:

1. The tablets are much more convenient to take than the capsules.
2. The percentage of reactions is still too high.
3. The total dosage and perhaps the time interval may be standardized but with highly susceptible patients, the detailed treatment schedule should be individualized.
4. Definite protection is secured by the use of oral antigen in the tablet form.
5. As others have indicated, this protection is relatively short.

In general then, specific prophylaxis is still an investigative study even after many years of uncontrolled usage. The best specific prophylaxis available to date are the oral active antigens. These give good but brief lasting protection and still produce a relatively high percentage of cutaneous reactions. A good extract in tablet form is more convenient to take than the extract in oil vehicles in capsules. The percentage of reactions may be reduced by careful individualization of dosage increase especially during the first few weeks of the dosage schedule. The duration of the protection may be increased by giving, as it were, "maintenance doses" of relatively high concentrations over a longer period of time, perhaps even several months.

Certainly for the highly susceptible individual all this is preferred to severe and often repeated episodes of poison ivy dermatitis. With the standardization of the extract and with the detailed studies in the chemistry of the irritating principles of poison ivy plants, great strides should be made in the future toward the solution of this problem of specific prophylaxis.

CONCLUSIONS

Because of the purely symptomatic treatment of poison ivy dermatitis attention had been drawn to the prevention phase. This prevention program includes the removal of the plant, the prevention of contact of the individual with the plant, the removal of the resinous plant material from the cutaneous surface and attempts to render the individual less susceptible to contact with the poison ivy plant. The Glendale Plan of Community Poison Ivy Control has demonstrated that a community control program is feasible and effective and is to be preferred to the individual control program.

In general, the prevention of cutaneous contact with the oleoresinous material of the poison ivy plant and the removal of this substance from the skin is unsatisfactory at the present time, especially with conventional remedies. Future work in this field has much promise, however.

For the investigative study of methods to render the individual less susceptible to contact, highly susceptible persons must be used, otherwise there are too many unknown and variable factors. These oral antigens which are active and stable are preferred for investigative use at the present time. Such antigens may be used in the tablet form. The dosage should be adjusted to the individual to avoid reactions in the early period of treatment, and an adequate dosage must be continued for relatively long periods to increase the duration of protection secured.

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Deaths on the battlefield are not the chief costs of war. Battle deaths comprise only 1 per cent of the armed forces per annum. Armies include about 10 per cent of the population of warring countries. Disease rates are about one per cent per annum. Thus diseases kill ten times more than battles, even in countries at war. Civilian mortality and morbidity are of military importance. The sanitary facilities that protect our population from the diseases that spread through inadequate water, sewage and food hygiene must be maintained and extended. The spread of tuberculosis and other infectious diseases should be prevented wherever practicable. . . These are all important war measures that should rank with military preparations in our national policy. —Lt. Comdr. Emil Bogen, MC, U.S.N.R. Amer. Rev. of Tbc. Mar. 1944.—Nta Clip Sheet.

Vagaries in Diagnosis and Treatment of Pernicious Anemia

FOSTER MYERS, M.D.

THIS subject is chosen for two reasons: to give a summary of the eight years of our Anemia Clinic; and to offer some suggestions on diagnosis and treatment, arrived at as result of the experience so acquired.

Obviously the whole subject of anemia is too large for one meeting. Hence, we will confine our discussion to some of our 85 cases of pernicious anemia diagnostic and therapy problems.

A DEFICIENCY DISEASE

Pernicious anemia is a deficiency disease. Its deficiency consists in the subnormal, or lack of, production of an intrinsic factor by the stomach. According to Meulengracht,[1] the pathology consists in the atrophy of the fundal glands of the stomach, rather than the pyloric, as has been held. Gastroscopists, as Chevalier Jackson[2] and Schlinder[3] draw a characteristic picture of the gastric mucoso of pernicious anemia—a grayish atrophy. Such mucosa not only can not produce the intrinsic factor, but also fails to absorb it, when the latter is given orally (liver, etc.). Hence, many cases do not do well on oral therapy.

SIGNS AND SYMPTOMS

Pernicious anemia, by Hayden's practical scheme, is a hyperchromic macrocytic anemia, with a high volume and color index (Chart I). Many profound anemias show macrocytosis, but in pernicious anemia, it is predominant (60 per cent to 80 per cent of cells). In our series, the 6 per cent not showing macrocytosis comprise those in remission with normal counts. Also the macrocytes, according to Isaacs, are oval rather than round. Bizarre shapes of reds are characteristic but not diagnostic.

In addition, other suggestive symptoms and signs help in diagnosis (Chart I). Achlorhydria, in our experience, is 100 per cent (although others, in rare instances, have found it present). If as Meulengracht[1] states, the fundal acid-bearing glands are atrophied, achlorhydria is readily explained, and he assumes that these fundal glands secrete an activator, (possibly Hcl or hormone) or are peacemakers for the pyloric glands, without which the latter can not function in producing intrinsic factor. The fact that with us this achlorhydria is associated with anorexia in only two-thirds of cases suggests that the former plays small role in latter. Progressive weakness and constipation are common.

It is interesting that, while only half the cases complain of sore tongue, 78 per cent show lingual atrophy. The loss in weight is frequently marked (40 pounds) and, contrary to earlier teachings, is not a differential point versus malignancy. Paresthesias are common, 74 per cent, while abnormalities in reflexes and vibratory sense are 60 per cent, and some of these show a return to normal under treatment. This suggests two types of neurological changes: A peripheral and a central, the former transitory; the latter permanent. We feel that neurological changes have little relation to blood changes, for the former regress or progress in presence of constantly well-maintained blood levels and, in several cases, have not occurred in spite of repeated relapses.

A positive family history of pernicious anemia is difficult to arrive at, since earlier diagnoses were confusing. Our figure of 7 per cent agrees

The Author

● Dr. Myers, Toledo, Ohio, is a graduate of Western Reserve University School of Medicine, Cleveland, in 1917.

CHART I

SURVEY OF 85 CASES OF PERNICIOUS ANEMIA

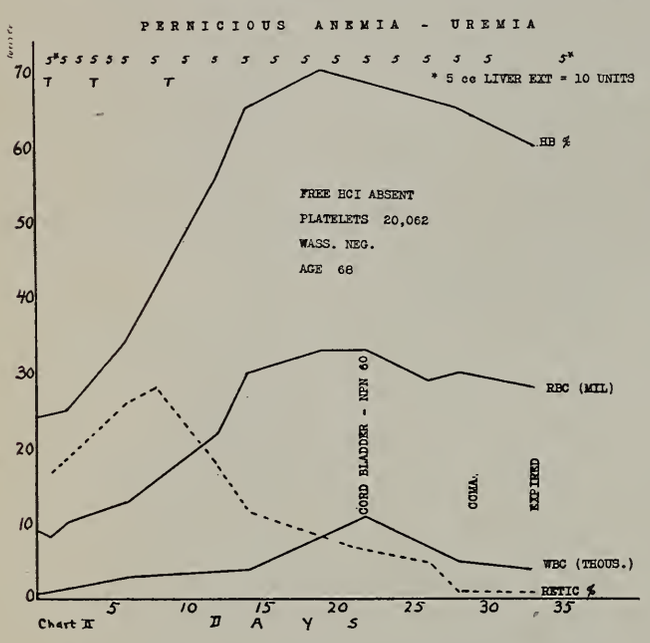
Symptoms	No.	Per cent
Progressive Weakness	85	100
Anorexia	56	66
Constipation	67	80
(not noted)	15	18
Sore tongue	39	46
(not noted)	23	27
Loss of weight	61	72
(not noted)	13	15
Numbness and tingling of extremities	63	74
(not noted)	7	8
Psychosis	18	21
Family History positive for Pernicious Anemia	6	7
Average Age	55	
Below 40	8	10
40–50	13	15
50–60	25	30
60–70	36	42
70– 4	3	3
Results—Improved	71	84
Unimproved	2	2
Expired	12	14

Physical Signs	No.	Per cent
Skin Icteric	56	66
Icterus Index (47 cases)		
Positive; above 6: Av. 13; H. 30; L. 7;	29	62
Free HCL absent	85	100
Tongue:		
Atrophy papillae	56	66
red, beefy, sulci	10	12
Hypotension	24	28
Reflexes:		
Normal	34	40
Absent	6	7
Hypoactive	19	22
Hyperactive	26	31
Pos. Babinski (22 cases)	8	36
Vibratory sense:		
Absent	40	57
Present	28	43
Red Blood Cells:		
Macrocytes	80	94
Color Ind. over 1.10	80	94
Wassermann positive	2	2
Platelets (47 cases):		
Below 100,000	8	30
Below 50,000	9	25
Cases with:		
Post.-lateral scler.	35	41
Prev. Gall Bladder disease	12	14
Psychosis	19	22

Cause of death of fatal cases:		
Anemia (RBC–1)	6	7
Uremia	2	2
Carcinoma stom.	3	4
Coronary occl.	1	1

with Meulengracht (9 per cent),[6] Levine and Ladd (6 to 7 per cent),[6] and is at wide variance with Murphy's 26.5 per cent[6]; and the former estimates that heredity in pernicious anemia is comparable to that of diabetes. Askey[7] and Muelengracht[1] state that early (pre-blood and pre-cord) potential diagnosis is suggested by the finding of achlorhydria in relatives and predicts that observation, and treatment where indicated, of these cases will be prophylactic. We have observed gastric analyses on very few cases of relatives with negative results. In the 2 per cent luetics with pernicious anemia, improvement occurred but incident to and retarded by syphilis. Of the nine cases showing thrombopenia (under 50,000), all were admitted with hemorrhages—nasal, retinal, cerebral; and all cleared up completely under anti-anemic therapy. The 62 per cent showing above-normal icterus index checks well with 66 per cent showing frank icterus. Average index was 13, with high of 30, and low of 7.

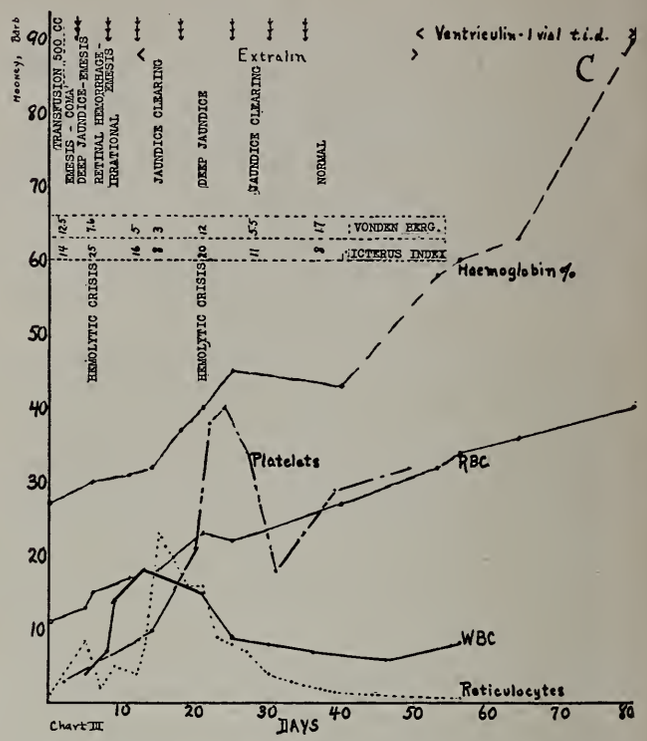
Our 41 per cent of cases with postero-lateral cord changes is at variance with the usual 75 per cent. Some of the cases have not had follow-ups since hospital discharge; such a check may



change our figures. Psychosis occurred in 22 per cent of cases. We have had the impression that many cases had previous liver or gallbladder pathology; and that this fact might have some bearing on the etiology. The low 14 per cent is a surprise and is within the normal ratio of general hospital admittances.

RESULTS

Our results are as shown on Chart I. Those showing improvements are all able to indulge in normal activities; some of the advanced cord cases are far from normal but are active. Of the two unimproved one refused adequate treatment; the other, well-treated, did not respond. Of the 14 per cent deaths, one-half were admitted in coma, with Rbc under one million and failed to respond. Their average hospital stay was 2.5 days, with maximum of 5 and minimum of 1. The ages were 52, 59, 61, 63, 65, 68, 78, with average of 64



E.M.—F57—Progressive weakness 7 weeks; nausea, polydipsia, constipation, vertigo, tinnitus, diminished vision; slight loss weight; sore tongue.

Jaundice 5 mos. ago. Menopause 5 yrs. ago.

P.E.—Icteric, no petechiae; tongue smooth; teeth out; heart tones weak, BP 100/60. Reflexes active, loss vibratory sense in lower extremity; liver enlarged. Achlorhydria. Wass. and Stools neg. Red cells large. T 101 P100.

Progress—Following transfusion, developed coma, emesis, jaundice (hemolytic crisis). Prompt clinical improvement with parenteral liver, and, later, extralin.

years. Possibly adrenal hormones might turn the trick; they have not been tried.

These cases, with profound anemia, are susceptible to genito-urinary pathology and this factor should be controlled. Chart II is such a case.

RELATION TO CANCER

Farquarson[8] of Toronto, states that 6 per cent of his cases developed carcinoma of the stomach. One might anticipate a much higher percentage inasmuch as both start as gastric atrophy and are frequently difficult to differentiate. Even X-rays are confusing, as will be shown later. Our 3 cases died 4-5 years after diagnosis of pernicious anemia was made. They had the usual response to anti-anemic therapy and no gastric complaints up to 3-4 months of death. And admission X-rays were negative. The ages were 54 (F), 64 (F), 59 (M). It has always been a question as to whether carcinoma is present from the onset of anemia. We think not. Lately, the sternal puncture and gastroscope have been of value as discussed later.

Pernicious anemia may simulate carcinoma. J.G., gave a positive X-ray evidence of car-

CHART IV

PERNICIOUS ANEMIA —— DIAGNOSIS AND THERAPY IN NINE ILLUSTRATIVE CASES.

Cases		R.B.C.	Hgb.	Vol. Ind.	Color Ind.	Max. Retic.	Free HCl	Ict. Index	Treatment
J.D. M	52 1931	2.92	65	1.40	1.50	10	0	8	q d : 8 vials or fresh liver
	61 1940	4.8	87		0.91	0.5			q 8 wks: Ly 1 c.c.**
J.G. M	62 1932	3.5	66		0.93	2.8	0		q 1 wk: Ld 6 c.c.*
	1932	Laparotomy negative for Ca. (2)							
	70 1940	4.2	71						q 3 wks: Ld 3 c. c.**
D.H. M	59 1934	1.57	36	1.15	1.05	17.	0	9	q 1 wk: Ly 6—*
	1939	4.4	85	D-Gastric Ca (2)					q 3 wk: Ly 5***— Ld 2** NA 200 mg
E.D. F	69 3/15/40	1.17	25	1.80	1.14	13	0	10	q d : Ld 1 c.c.**
	3/18/40	Sternal puncture—early erythrocytes (Megaloblasts) 75%—P.A.							
	3/20/40	G. I. Series—extensive malignancy of stomach							
	3/30/40	Gastroscopy—pale gray mucosa; no atrophy; no malig.							
	11/18/40	4.2	86						q 3 wks.—Ld 3**
R.E. M	46 1933	1.34	40	1.17	1.33	9	0	5	q 1 wk: Ld 6 c.c.* I.V.
	1936			Empyema gall bladder (2)					
	1940	5.2	93						q 4 wk: Ly 1 c.c.**
I.C. F	55 1933	1.72	68	1.58	2.00	10	0		q 1 wk: Ld 9 c.c.* Extr. 16 cap.
	1937	3.2	70	Myxedema (4)				BMR—20	q 2 wk: Ld 3**
	62 1940	4.	82					BMR+20	q 2 wk: Ld 3**— — Extr. 16 Thyr. gr. II
F.J. M	1937	1.05	30	1.30	1.43	12	0	7	q d: Ld —1** Ly — 5***
	59 1940	4.3	88		1.02				q 3 wk: Ld 2** Ventric. 20 gm.
P.J. F	2/1940	1.82	40	1.50	2.22		0	3	q 1 wk: Ld 2**
	48 10/1940	4.2	82		0.95	Post. lat. sclerosis			q 2 wk: Ld 3**
	S.P.—36% early erythrocytes (megaloblasts)								Vent. 20 gm.
C.F. M	58 1936	2.5	62	0.84	1.26	18	0	10	q 2 d: Ly 5*** Ld 3** (R)
	1940	4.5	91	Marked post. lat. sclerosis					q 2 wk: Lyp 4**— Ly 5*** NA 300 (2 yrs) Vent. 20

*3cc liver ext=100 gms fresh liver; **1cc liver ext=15 units; ***1cc liver ext=2 units.
NA=nicotinic acid; Extr.=extralin cap.

cinoma of stomach; laparotomy disproved this. In the past 8 years, he has remained well on parenteral liver extract; oral therapy is not effective with him. Another case, with positive X-ray evidence of peptic ulcer, proved negative to laparatomy. Recently, of two cases with identical histories, physical, and blood findings, one was proven pernicious anemia by sternal puncture and gastroscope; the other shown by the same method not to be pernicious anemia, later developed abdominal malignancy. E. D. presents much the same story; the bone marrow picture of 75 per cent early erythrocytes (megaloblasts) was definite evidence of P.A., the gastroscope clinched it. While our experience is limited, we feel these measures may be of definite diagnostic value.

On the other hand, carcinoma may be missed or developed later, as in the case of D.H. The fact that his anemia showed prompt response to therapy, with good reticulocyte rise; and that he remained robust (farmer) and well; maintained his health without gastric complaints up to 3 months prior to death, all would suggest that the carcinoma developed later on an existing pernicious anemia.

Gallbladder disease is not uncommonly associated with pernicious anemia and one wonders whether there is an etiological relationship. Strangely enough, R.E. kept a normal blood level for 1½ years, following cholecystotomy, before again requiring therapy. This was true of another case, 15 units a month maintains them. Myxedema has been present in four of our cases, mild in type. It definitely interferes with response to therapy unless thyroid extract is given. I.C. presented what we thought was a refractory response to liver, until mild edema, mental sluggishness and a B.M.R. proved myxedema. Still requiring considerable therapy plus thyroid, she is in better health than in years. (Auricular fibrillation occurs promptly, if thyroid extract is increased from usual gr ii to gr iii.)

Is pernicious anemia a dietetic (or marital) failure? F. J. and P. J. are husband and wife, who developed pernicious anemia within 3 years of each other. Is this coincidental? Or is it attributable to some faulty living and dietetic habits? It has some features of transmissibility in that husband, the first to be involved, has uncomplicated pernicious anemia, while the wife, with onset this year, has marked cord change and requires more therapy. Rhoads is convinced that pernicious anemia is pre-eminently a dietetic deficiency, conditioned by subversive factors—i.e., some element of Vitamin B complex.

THERAPY

The therapy in pernicious anemia is an individual problem. Occasionally, one sees a typical response, as in Chart III. Here the additional feature of thrombopenia, profuse nasal hemorrhages, and hemolytic crises during therapy, are present. Since the onset in 1935, she has had, through neglect, several relapses (with again hemorrhages and thrombopenia); but at no

time has she exhibited any neurological changes. When she reports regularly, she is well maintained on 15 units a month.

Other cases vary widely, in response to therapy, for various causes (Chart IV). Some, as J.D., are well maintained on 15 units every two months; six others, not shown, come in this class.

Oral therapy has not been adequate in any of these cases; and it is never recommended for neurological cases except in conjunction with parenteral.

SEVERE SCLEROSIS

Finally, severe postero-lateral sclerosis requires much more therapy than those without it. Minot[10] says at least 10 units a day; and extracts of low concentration are recommended, rather than high or in conjunction with high. Meulengracht[6] suggests, in addition to parenteral, ventriculin, 20 gms. day. Yet, with all this, C.F. has periods of regression and progression of symptoms and signs, in spite of high blood level. However, while ataxic and clumsy in use of hands, he is active and cheerful and very much improved over his bedfast condition on admission. Nicotinic acid has been suggested in these cases; he has had it daily (except for short break) for 2 years, without demonstrable objective changes (or toxicity), although the vasodilation it produces seems to increase his peripheral circulation and relieve the coldness of the extremities. Nicotinic acid has been used in a number of other cases over long periods with no striking results, as above, and no toxicity. Vitamin B_1, in doses 20-50 mg. t. i. d. parenterally, has no effect on symptoms or pathology or in reducing requirement for liver therapy; and in C.F. the paresthesias were sharply increased. Orally Vitamin B complex, as Vegex, Brewers' Yeast, or in capsules, helps constipation only.

REACTIONS TO LIVER

The reactions from parenteral liver are of three types: (1) simple flushing and sense of heat; (2) itching and urticarial wheals, anywhere, especially hands and feet; and (3) syncope. J.D. and R.E. are of first type, D.H. of second, and C.F. of third. These reactions are of an allergic type and are usually acquired after long administration of liver extracts; but they may be initial. And once sensitive, they may react to oral liver. Usually, frequently changing the make of extract will suffice; sometimes the change to horse liver products is necessary. The use of ephedrine or benzedrine before injections, will frequently control them. The third syncope is alarming and has all the appearance of exodus; prompt adrenalin therapy has prevented several possibile fatalities. We have never had to stop parenteral use of therapy for any cause; but the reactors are treated cautiously. We have had many of first type, a few of second, and five of third.

Our initial therapy has been varied in each case, as conditions or new ideas indicate; in general, 15 units a day for 10 days, followed by maintenance doses as indicated.

CONCLUSIONS

1. Pernicious anemia is a macrocytic, hyperchromic, deficiency disease.
2. The symptomatologies are presented in detail. The hereditary factor and effort at pre-anemia diagnosis by finding of achlorhydria in relatives, may be the method of control.
3. The results of treatment showed 84 per cent improved, 2 per cent unimproved and 14 per cent dead. These are analysed.
4. The diagnostic problems and therapy are shown in 9 cases. The differential diagnosis from carcinoma presents a problem; sternal puncture and gastroscopy may help here. Cord changes still present our greatest problem; their response to heavy therapy is still far from satisfactory. Vitamin B complex and nicotinic acid are of doubtful value.

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Electrocardiography

Most electrocardiograms are taken of patients presenting either disturbance of cardiac rhythm or evidence of suspected myocardial disease secondary to diminished coronary bloodflow. The tracing is diagnostic for the type of arrhythmia encountered, but reflects the situation only at the moment the record was made. With myocardial disease the problem is far more complex.

No single electrocardiographic record is ever invariable proof of thrombotic infarction of the myocardium and coronary occlusion does not invariably produce a characteristic tracing. Repeated recordings, to note changes occurring at intervals as the infarction progresses or heals, are fully as important as the so-called characteristic changes produced by the infarction. Confusing records, at times similar to those of coronary disease, may be produced by renal disease, pericarditis and various medications. It should be distinctly understood that an electrocardiogram is of greatest value when interpreted in terms of the specific patient and cannot be substituted for the clinical findings.—William J. Bruckner, M.D., New Haven, Conn. State Med. Jour. Vol. VIII, No. 6, June, 1944.

Postoperative Care and Complications of Gynecological Patients

ROBERT L. FAULKNER, M.D., and E. A. RIEMENSCHNEIDER, M.D.

POSTOPERATIVE care of the gynecological patient is as important as the operation itself. Only by careful attention to the small details which present themselves following operation can the physician insure the patient's comfort and satisfactory convalescence. Standing orders may be used in a well-regulated hospital to cover all ordinary situations of diet, perineal care and other routine matters, but a watchful eye must be directed at all times toward any unusual circumstances which may aid in the early detection of postoperative complications.

In a general way the postoperative care of a gynecological patient is the same as that used after any abdominal operation not involving the bowel. Likewise the possible complications may be approximately the same. However there are some details in gynecology which do not present themselves frequently in general surgery. There are many systems of postoperative care. This resumé is an outline of our practice and is, of course, not presented as the only system of postoperative care.

The care after operation of any surgical patient must be individualized depending upon the patient's personality and the extent of the operation, but a few broad rules and suggestions which may be followed in all patients will be outlined.

RELIEF OF POSTOPERATIVE PAIN

Morphine and plenty of it is the general practice following pelvic operation. The patient must be kept comfortable and this can be done only by the unstinted yet judicial use of narcotics. It is noticed in talking to students of these matters that they are not usually aware of the fact that up to the present time there is no substitute for opium in common use. The hypnotics do not relieve pain. As a rule an order for a quarter grain of morphine every four hours as necessary for pain will suffice. It is well to remember that morphine may prolong the period of nausea in some patients and these should be given pantapon or dilaudid which may be better tolerated. After three or four days codein may be utilized. A milder sedative or hypnotic at bed time may decrease somewhat the amount of narcotic needed.

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FLUID INTAKE AND OUTPUT

Immediately following operation fluids are given to replace the loss during operation. In recent years the intravenous administration of fluids has become more popular in many hospitals. Postoperative orders are written for the measurement and recording of fluid intake and output. A daily intake of at least two thousand cubic centimeters must be maintained. If the patient is unable to take fluids by mouth, intravenous or subcutaneous administration is necessary. Because of the danger of ureteral damage in pelvic surgery the urinary output must be known exactly for some hours following operation.

CARE OF THE BLADDER

Following operation, definite orders for catheterization are left to be used in case the patient is unable to void 100 cc. or more at a time. The order usually calls for catherization if necessary every eight hours. After some vaginal operations, especially involving the anterior vaginal wall, an indwelling catheter is left in place at the time of operation. Such catheters should be cared for by occasional irrigation and by daily instillations of an appropriate antiseptic, especially if they are to remain in the bladder for any length of time.

It is well to remember that a patient may void small amounts frequently on an overdistended bladder, the so-called paradoxical incontinence. It is mandatory to catheterize any patient who is not voiding properly for residual

urine and to do so until the amount of the residual becomes small.

As a rule a gynecological patient should be voiding on or before the time of her enema on the morning of the fourth day. If this does not occur an indwelling catheter is often used. At other times an ounce of 0.5 per cent aqueous solution mercurochrome or sterile glycerin placed in the bladder may cause it to empty. Prostigmin is popular with some men. The modus operandi of this drug is presumed to be through stimulation of the paralyzed parasympathetics.

DIET

During the first twenty-four hours warm water or cracked ice is given depending on personal practice. Thereafter in gynecology the diet may be increased routinely without the necessity for leaving constant orders except under special circumstances. The practice of feedings soon after operation has not been adopted yet except for the occasional patient who desires more food. On the first postoperative day the diet is clear liquids; on the second toast is added; and on the third a full liquid diet, with a soft tray being given on the fourth day. A full tray is started by the fifth day after operation. In patients with distention, cold milk and fruit juices are withheld. Of course all patients may have a full tray on the first day following minor operations if desired.

CARE OF THE BOWELS

On the night of the third day following operation an oil or other mild laxative is ordered and then left to be given as necessary. The morning of the fourth day a soap or glycerin and water enema is given and used as necessary thereafter. In elderly patients, particularly, bowel function must be carefully watched to avoid fecal impaction.

CARE OF THE ABDOMINAL WOUND

The wound is dressed with gauze and plenty of adhesive at the time of operation. The first dressing is done on the fifth day unless there is morbidity, excessive drainage, or rarely when a drain is left in at operation. At the first dressing skin clips or silk sutures are removed. If the skin is not thoroughly approximated it is well to remove only every other clip or suture leaving the remainder for a day or two. Stay sutures, used routinely by some men and in special circumstances by others, are removed on the tenth day. All house officers, of course, know about and keep watch for signs of wound eruption or dehiscence. This complication, though rare, calls for early detection.

PERINEAL CARE

There is considerable variation in different clinics as to the amount of care given the perineal wound if present. In many institutions this is part of the nursing routine and the average busy doctor knows very little about what goes on. There is a feeling that the perineal wound will usually take care of itself if left alone. Recently the nursing shortage due to the war, with inability to carry out the complicated program previously used has confirmed this impression.

At the present time the perineum is left alone except as the occasional fastidious patient may complain of discomfort, when a warm water or bichloride irrigation may be used. From early in convalescence all patients with any perineal operation have dry heat applied to the perineum three times a day from a heat light containing a twenty-five watt bulb at a distance of nine inches. This is used for thirty minutes.

Following any usual pelvic operation an alkaline douche may be started and continued after the tenth day with comfort to the patient.

POSTOPERATIVE COMPLICATIONS

Shock: Shock may be one of the earliest postoperative complications, occasionally occurring while the patient is still on the operating table. In pelvic surgery there should rarely be serious shock without excessive loss of blood since operations in the lower abdomen are generally well tolerated. All this is tempered with the understanding that the patient has been properly selected for the operation and then well prepared. Proper control of temperature and humidity in the operating room and the performance of and close attention to the sedimentation rate in gynecology has aided us in lessening materially the incidence of shock. Women with any degree of pelvic infection with or without other conditions are not operated on deliberately.

The characteristics of shock are well known. It may be immediate or delayed. Adequate treatment is necessary long before the condition becomes irreversible. The customary treatment still includes elevation of the foot of the bed, application of external heat, with care not to load the patient down with heavy blankets, administration of vascular stimulants such as adrenalin or ephedrine, and most particularly the correction of the volume of intravascular fluid. In an emergency, hypertonic glucose is given at once, but because this is rapidly excreted, plasma or whole blood is the most effective therapy. In patients who are not exsanguinated plasma or serum is sufficient. Administration of oxygen is finally of some value in the treatment of shock.

Hemorrhage: In spite of modern good suture material every surgeon probably has at some time had an unexpected postoperative hemorrhage. The incidence however may be kept

down materially in pelvic surgery by developing the invariable habit of meticulously and completely double-tying the pelvic pedicles. Hemorrhage when it occurs is usually in the first five or six hours but may appear as long as forty-eight hours following operation. Its detection and diagnosis from those patients presenting pure shock is usually easy in pelvic surgery because if hemorrhage occurs in gynecology it is apt to be a real one. The obvious signs of exsanguination are present.

Treatment of course consists of immediate supportive procedures and transfusion of citrated whole blood with immediate operation to find and tie off the bleeding vessel. So often at operation in the presence of lowered blood pressure the exact bleeder cannot be found and all pedicles must be retied. Auto transfusion of the blood found in the abdomen may occasionally be done, under the proper precautions.

Abdominal Distention: This complication may be very troublesome. Simple treatment of distention must not be forgotten. The rectal tube and hot abdominal stupes of some variety may be all that is necessary. If the bowel has not been injured a single enema may aid in restoring the siphon-like function of the bowel, but continued enemas probably aid very little as a rule. Administration of prostigmin is popular with some men. In persistent distention, especially if there is vomiting, use of the Wagensteen or Miller-Abbott tube should not be delayed. This is true of any distention but the early use of the tube should particularly be remembered if the distention is upper abdominal (acute dilatation of the stomach). With the tube in place continuous suction deprives the body of chlorides and these must be replaced by intravenous or subcutaneous administration. Five per cent glucose may be given intravenously with the chlorides. The patient will thus receive much needed supportive treatment.

In pelvic surgery there is probably very rarely a paralyzed bowel without actual reaction in the pelvis involving one or more intestinal loops. The possible exception is in the aged. By the use of the Miller-Abbott tube in these persistent and often desperate patients with abdominal distention, the incidence of intestinal obstruction calling for ileostomy or other operation has been materially reduced. The Miller-Abbott tube is in effect an internal ileostomy. Its use tides the patient over that period of convalescence in which the bowel is involved. Repeatedly in gynecology these partial obstructions take care of themselves after a few days. The only time that considerable trial of the tube is not indicated is in actual gangrene of a segment of the intestine. This should not occur very frequently postoperatively.

Urinary Infection: Mild infection of the bladder is very common after pelvic operation. When catheterization is necessary it should be done carefully and kept to a minimum. Postoperative watch of the urine with prompt administration of urinary antiseptics if the findings are abnormal is furthermore of great help not only in shortening the period of bladder symptoms but also in avoiding pyelitis. With the aid of the sulfa drugs it is now probably unnecessary to encounter pyelitis very often if the postoperative urinary findings are adequately followed. In the presence of an indwelling catheter early prophylactic use may be made of these drugs since at least a cystitis is inevitable.

Phlebitis: From the nature of pelvic surgery with its mass ligatures and performance in close proximity to major vessels a certain incidence of phlebitis is to be expected. This however is not peculiar to pelvic surgery. The chief interest in this condition should be its prevention including both operative and postoperative measures. There is an impression that suture surgery instead of clamp surgery lessens the incidence of phlebitis. Retractors should be used with all possible gentleness. Hemostasis particularly of the rectus muscles should be complete.

After operation early and steady activity of the patient is desirable. The practice of putting a pillow into the foot of the bed for the patient to kick is probably a good one. It is customary to give many patients a grain of thyroid extract per day to stimulate circulation as suggested by Walters some years ago.

Once phlebitis develops, treatment consists of rest in bed, heat to the legs, and elevation. There is to be considered also procaine block of the lumbar sympathetic ganglia as advocated by Ochsner. It is a curious thing that patients with symptomatic phlebitis seldom throw emboli, at least of the massive type. Greater fear of massive embolus is entertained by the gynecologist in the case of patients who maintain an unexplained low grade temperature following operation. Such patients are sometimes gotten out of bed with fear and trepidation.

Pulmonary Complications: Atelectasis is usually the earliest pulmonary complication following operation. Symptoms vary with the size of the area affected. A small alveolus may be plugged or the atelectasis may be so severe as to give massive collapse of a whole lobe of the lung. Physical and X-ray diagnosis is quite characteristic with sudden onset during the first three postoperative days. There is a temperature rise accompanied by a respiratory rate of thirty to forty per minute. The symptoms and signs of atelectasis are well known and X-ray findings confirm the diagnosis.

Postoperative pneumonia is essentially the

same as pneumonia affecting the patient at any other time.

Pulmonary embolus is characterized by sudden sharp chest pain coming on late in the post-operative period. Signs and symptoms are quite characteristic and may be confirmed by X-ray and electrocardiographic examination.

GENERAL CONSIDERATIONS

The patient will be given more assurance and the doctor will save himself telephone calls if at the time of discharge some definite conversation is had relative to the details of further convalescence. These include care of the wound, of the bowels, the use of the douches, hypnotics if necessary, and other instructions having to do with particular circumstances. An approximate time is set for the patient's first return visit to the office.

No gynecological patient should be discharged from the hospital without a pelvic examination. The purpose of this examination is to see that all sutures, packs, sponges and drains have been removed. The physician has very little shelter from at least some embarrassment if after going home the patient calls up and states that she is delivering a pack or sponge. In spite of any system, no matter how conscientiously observed, a neglected sponge may be left in the vagina or stay sutures may remain in the abdominal wall. This is as true on a gynecological service as it is on a service where all surgical patients are thrown together.

Preventive Medicine in Industry

The mathematical analysis of blood pressure records shows that for maintenance of physiological normality there must be a balance between the rate of development of abnormality while at work and the rate of recovery while away from work. If development is faster than recovery, we can demonstrate the stages reported in the *Medical Clinics of North America*, namely:

1. A period of no detectable physiological defect.

2. A period in which functional abnormality has developed at the end of the day's work, but disappears over night.

3. A period in which functional abnormality has developed at the end of a week's work, but disappears during the week-end of rest.

4. A period in which over-night rest is not adequate to restore to normal.

5. A period in which week-end rest is not adequate to restore to normal.—John H. Foulger, M.D., Wilmington, Del.; Vol. 37, No. 6, The Jour. of Indiana State Med. Assn., June, 1944.

Fungus Allergy and Industrial Dermatitis

Criteria have been laid down for a diagnosis of trichophytids which are absolutely diagnostic, but, of course, it is not possible to carry out all of the criteria and in the differential diagnosis of trichophytids from other types of skin eruptions only a few of the criteria need be established. The complete criteria are as follows:

1. The causative organism must be demonstrated in what is recognized by every one as a classical manifestation of the disease.

2. While it is not absolutely essential, the organism which is cultured from the primary lesion should be pathogenic.

3. A positive reaction analogous to a tuberculin or a trichophytin reaction must be present.

4. What is considered to be microbid should be seen as frequent accompaniment of the primary lesion.

5. Positive blood cultures for the same organism isolated from the primary lesion must be obtained, since it is admitted that most of the microbids are hematogenous eruptions.

6. The microbids must develop subsequent to the primary infection.

7. The microbids must usually be sterile.

8. A support for the conception of a skin eruption as an "id" lies in certain clinical characteristics:

   a. Appearance of the "id" in showers.
   b. Tendency to symmetry in distribution because of hematogenous origin.
   c. Tendency to spontaneous involution after healing of the primary focus.
   d. Focal reactions after injection of sufficient amounts of microbidin (trichophytin).

The following criteria are practical and should be carried out in the differential diagnosis of contact dermatitis and "ids":

1. The presence of an active fungus infection should be established.

2. The trichophytin test must be positive before a diagnosis of "ids" is made.

3. The eruption on the hands suspected of being an "id" should not improve after a suitable removal of contact with known or suspected industrial irritants.

4. No improvement should occur when fungus infection on the feet is treated if we are not dealing with "ids."

5. The clinical appearance of the eruption must be borne in mind.

   a. Trichophytids are more frequently seen on the palms and on the sides of the fingers, flexor portion.
   b. Contact dermatitis is most often seen on the dorsum of the hands.—Samuel M. Peck, M.D., Bethesda, Md.; Vol. 37, No. 6, The Jour. Indiana State Med. Assn., June, 1944.

New Methods of Anesthesia and Their Application in Office Practice

NORRIS E. LENAHAN, M.D.

IN the past ten years the study and practice of anesthesia have made remarkable advances. No longer is anesthesia considered the step-child of the surgeon, but is now regarded as a true specialty having its own board, The American Board of Anesthesiology. The greatest impetus toward this end was the many new anesthetic agents discovered and the specialized skill required for their proper administration.

The chief objective of this paper is to acquaint you with some of the more commonly recognized office procedures requiring the use of local anesthetics.

Many times anesthesia of a part or area is required and no available anesthetist or anesthetic equipment is available. In this case the blocking of the nerve or infiltrating the area with novacaine or related compounds proves very effective, and has long been employed by the dental profession and ophthalmologists.

The two most important methods of local anesthesia are:

I. Infiltration anethesia.

II. Nerve block or regional anesthesia.

I. Infiltration anesthesia may be used in the following manner:

1. Removal of small tumor masses and foreign bodies.
2. Parencentesis and thorencentesis.
3. Repair of lacerations.
4. Reduction of fractures.
5. Treatment of non-weight bearing fractures.
6. Treatment of sprains and contusions.
7. Treatment of low back pain.
8. Treatment of shoulder disabilities due to sore painful muscles.

II. Nerve block or regional anesthesia may be used as follows:

1. Brachial plexus block—for all disabilities of arm and forearm.
2. Tibial block for leg injuries of various kinds.
3. Intercostal block for fractured ribs or rib resection.
4. Wrist block; radial and ulnar block.
5. Caudal and continuous caudal.

INFILTRATION ANESTHESIA

1. Removal of Foreign Bodies. I think we are all familiar with the use of novacaine in infiltrating small areas for the removal of foreign bodies. A skin wheal should be raised with a fine needle and then a larger 21 gauge needle introduced through this anesthetized area infiltrating below the object, fanning out in different directions as necessary. A pause of three to five minutes is usually necessary for full effect, then the incision may be made. Novacaine solution of .5 to 1 per cent may be used.

Aided by a grant from Comly Fund for Research, Ohio State University.

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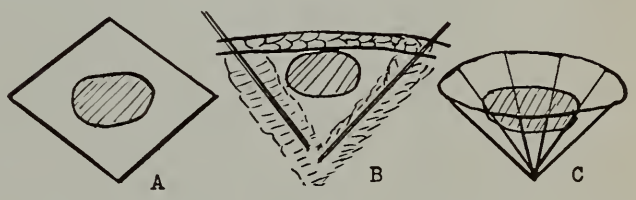


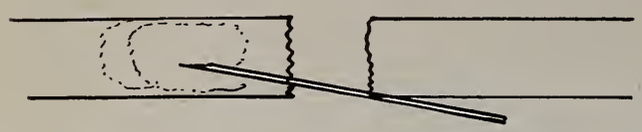
Fig. 1. Field Block for biopsy of lymph node. A, outline on cutaneous surface of diamond shaped field block; B, the node is continuously palpated throughout the injection in order to avoid losing it; C, multiple subcutaneous infiltrations. (Lundy's *Clinical Anesthesia*, W. B. Saunders Co.)

2. Paracentesis and Thoracentesis. A skin wheal is made with a fine hypodermic needle using 1 to 1½ per cent novacaine solution. Then a 21 gauge needle is attached to the syringe and is inserted through this anesthetized area as deeply as needed. The injection may be made as the needle is inserted or as it is withdrawn.

3. Repair of Lacerations. In the event one is faced with a laceration in which the skin edges are gaping widely an injection of novacaine can be made from the cut surface and fanned out as necessary. By doing this multiple needle pricks through sensitive skin is unnecessary.

4. Infiltration in Reduction of Fractures. (a) Fracture with hematoma. A 2 per cent solution of novacaine or metycaine is used. The needle is inserted so that a drop of blood may be aspirated from the hematoma. The blood from a hematoma usually contains fat globules and is darker than blood from a blood vessel. A very important point involved in making the injection is the speed of the injection. It should be

done very slowly so that if systemic signs of toxicity are to be evident they will be from a small does rather than a large one. For the average Colles fracture 10 cc. of solution is used;



for a fractured femur 50 cc. The anesthesia appears in a few minutes after the injection is made and lasts several hours.

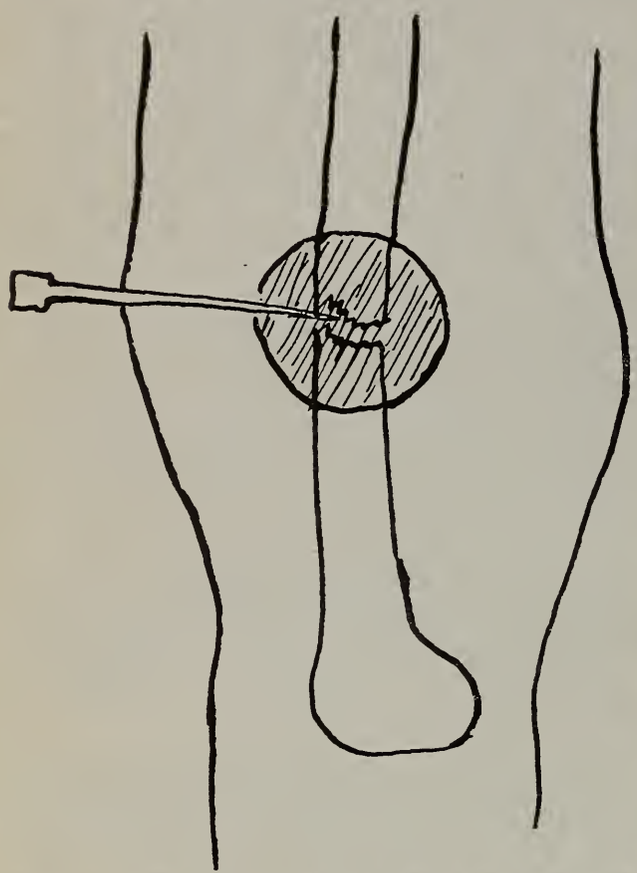


Fig. 3. Injection of fracture with hematoma. The needle penetrates the hematoma and comes to rest at the site of fracture, solution is then injected so that it diffuses through the hematoma. (*Lundy's Clinical Anesthesia*, W. B. Saunders Co.)

(b) Closed reduction of fractures without hematoma. A .5 per cent solution of procaine or

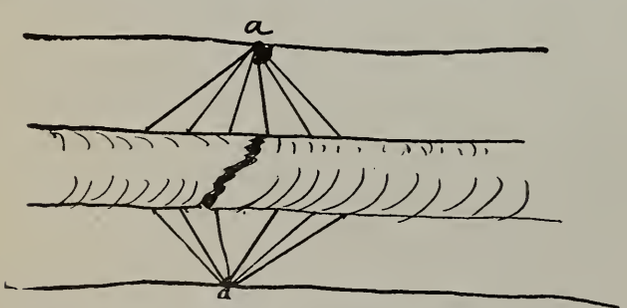


Fig. 4. Infiltration of fracture without hematoma, A, skin wheals. Broken lines show direction of needle. Infiltration is made against all of the broken periosteum. (Lundy's *Clinical Anesthesia*, W. B. Saunders Co.)

metycaine with 1 cc. of 1/2600 adrenalin per 200 cc. is used. Skin wheals are made and the solution is injected as illustrated down to the periosteum. From 20 to 50 cc. of .5 per cent solution is deposited against the periosteum. Anesthesia is usually effective in five to ten minutes. A preliminary of morphine is advantageous.

(c) Infiltration for fractured rib. Although a tight adhesive tape strapping is placed over a fractured rib, pain usually persists. This can be relieved by simply injecting a 1 per cent novacaine solution into the line of fracture. If necessary the rib above and below may be injected as well. This procedure may be repeated if necessary. Rarely is it necessary to inject the area more than two or three times.

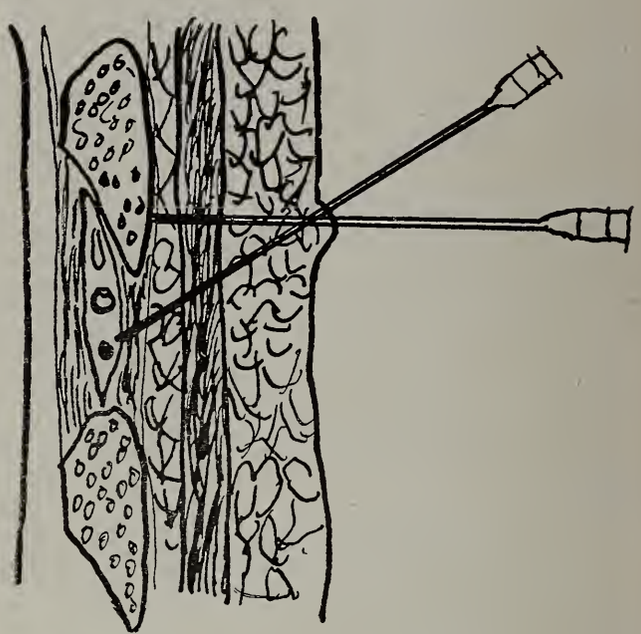


Fig. 5. Site of injection for fractured rib.

5. Treatment of Non-Weight Bearing Fractures. L. Kraeer Ferguson[1] cites this method of treatment in well over 200 cases. In our own experience although not having such an imposing number the method has worked well. The theory back of the treatment is as follows:

(1) Procaine injection relieves discomfort and edema, thus permitting early resumption of activity.

(2) This measure allows more adequate blood supply which produces early and excellent fracture healing.

(3) Early mobilization is of value in minor fractures in region of joint, because it prevents adhesion formation and stiff joints. In addition it allows nature to accommodate for any deformities in the articulating surfaces as they occur in actual use.

Technique. After careful skin asepsis a skin wheal is made over the point of maximum tenderness. A large needle is then introduced and novacaine or pontocaine is injected until there is no more pain. The part is massaged to insure thorough dissemination of the novacaine and this

also possibly aids in the absorption of the edema. The part is then wrapped with an Ace-elastic bandage. The patient may then use the part normally but not to test it. Weight bearing in ankle injuries is permitted in five days. The average period of disability was 15 days. Fractures of tarsal and metatarsal bones can be treated by injection and adhesive strappings. Fractures of toes and fingers are best treated by injections and early mobilization. Every one has seen stiff fingers and toes as a result of prolonged immobilization.

6. Treatment of Sprains and Contusions. The advantage of the use of local anesthesia in the treatment of temporarily disabling lesions such as contusions and sprains are as follows:[2]

a. Pain is immediately and completely relieved.

b. An immediate resumption of work or duty is often possible.

c. Use of narcotics or sedatives often unnecessary.

d. Patient can often be treated as an out patient.

e. In chest injuries excessive coughing is reduced and normal respirations are possible.

f. The treatment can easily be carried out in the office.

g. No skin irritation from strapping with adhesive.

h. One definite contra-indication is clear. This method is not adaptable to open and dirty wounds.

(1) A sprained ankle may be treated in the same manner as was the non-weight bearing fractures. The essential difference being that the patient is able to be up and about almost immediately. The ankle should have an elastic support. Pain is relieved for varying lengths of time—two, six, eight hours. It may be re-injected several times with the 1 per cent novacaine solution without difficulty or causing pathology. Additional adjuvants are whirlpool baths, massage, and heat in the form of the conventional bakers.

(2) Contusions of the chest without fracture. Contusion of the chest without fracture produced by trauma brings about the following symptoms: severe pain in the chest, limitation of motion and breathing. These symptoms are relieved by the injection of novacaine into the painful area.

Technique. The skin is carefully sterilized with merthiolate. An intradermal wheal is raised over the center of the affected area. Through this wheal it is then possible to introduce the anesthetic into the deeper tissues. As a rule five to ten cc. is sufficient but occasionally fifteen to twenty cc. of a 1 per cent novacaine solution or ¼ to ½ per cent solution of pontocaine may be used. A sterile dressing is then applied. In one to six hours pain may return but it is usually less severe and disappears in a few hours. However if the pain persists the area may be reinjected.

7. Low Back Pain. The clinical features are constant.[3] "The patient's foot slips while he is cutting corn and bending down and a severe pain grips him in the lower part of his back. Or he is lifting a heavy load when he is suddenly seized with pain. He is able to work after a fashion but when he goes home and 'cools off' his pain becomes severe. Every movement is now extremely agonizing so his wife is sent for some Dr. Doan's Kidney Pills. After a few days his pain moderates and he can walk but is unable to bend over and tie his shoes. He then consults a doctor." Assuming an X-ray shows no bone injury slipping forward of the fifth lumbar vertebrae on the sacrum or ruptured inter-vertebral disc he is a subject for injection.

Group A. "In this group the pain and tenderness are confined to the iliac crest attachments of the longitudinal muscle mass consisting of the sacro-spinalis, latissimus dorsi quadratus lumborum and their associated muscular attachment to the iliac crest is torn and a local spasm results which keeps the injured fibers from approximating and healing so that when the patient stoops the spastic and resistant fibers tear still further, perpetuating the injury."



Fig. 6. Site of injection of local anesthetic in Group A.

Treatment. At three points on each side of the crest inject 30 cc. novacaine in saline making 180 cc. in all. Massage the area vigorously with the hand or knuckles to disseminate the solution and to break down intramuscular adhesions. The patient is then encouraged to perform all movements which were previously painful. Then the back is thoroughly strapped in lumbar lordosis. Apply three inch tape from tip of coccyx to shoulder girdle. Apply seven strips longi-

tudinal and every second strip apply a strip horizontally around the waist.

Group B. Pain and tenderness are situated over one or both sacro-iliac joints. The sacro-iliac joint can be likened to a dovetail joint with interlocking flanges. Injury to this joint consists essentially of tearing the lumbo-sacral fascai and sacro-tuberous ligament and ilio-lumbar ligaments and a slight separation of these interlocking parts.

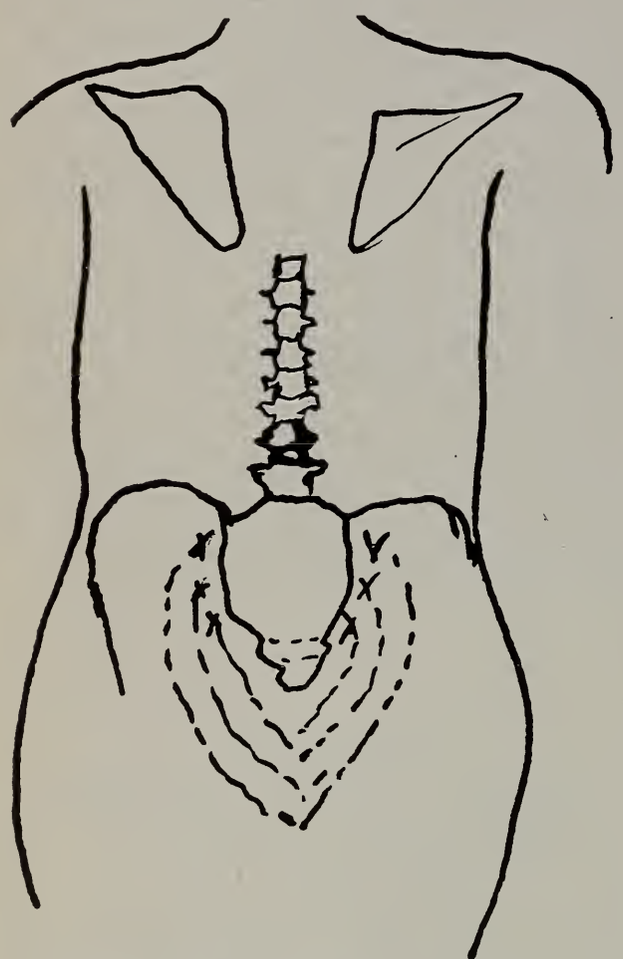


Fig. 7. Site of injection in Group B.

Treatment. Feel for ilial tuberosity between transverse process of the fifth lumbar vertebrae and the posterior iliac spine. Insert needle at the points shown tangentially until the rough surface of the tuberosity is encountered, then move needle medially when it is felt to sink into the fascial and ligamentous mass until the lateral edge of the sacrum is reached. At each of these three points on each side introduce 20 cc. of ½ per cent novacaine solution. Forcibly massage as before and then make the patient perform a full range of movement.

The patient lies in a position of lumbar lordosis. Four overlapping layers of three inch strapping are used. Commence on the right side at the level of the tip of the coccyx and draw the right buttock forcibly toward the midline and then apply the plaster commencing four inches ventrally to the great trochanter of the femur and pull strongly to the left. Now draw the left buttock medially and finish off the plaster at the corresponding point on the left side. The plaster remains on the patient 10 days and then a sacro-iliac belt is worn if necessary.

8. Pain and Disability of the Shoulder Joint. "When a patient presents himself with common complaint of pain in the shoulder region and arm with or without limitation of motion and unrelated severe trauma, the physician usually thinks of bursae, tendons, joints and nerves rather than muscles as the source of pain. Thus the customary diagnosis is arthritis, sub-acromial bursitis, brachial neuritis or radiculites."[4]

It has long been recognized that many instances of "painful shoulder syndrome" present tender areas in the muscles around the shoulder (periarthritis). It has been demonstrated that tender areas in muscles may cause pain not only locally but also referred to other sometic structures.

The minimal criteria for the diagnosis of shoulder and arm pain due to "idiopathic myalgia" on the basis of which infiltration with procaine may be successful are:

(a) Increase pain on active motion elicited either by quick or sustained effort.

(b) Tender points in the muscles of the back or shoulder girdle.

Reproduction of spontaneous pain pattern by pressure on the tender point and limitation of motion are valuable signs when present but are not essential to diagnosis. Let us assume we press on a "trigger point". Such area is exquisitely tender to pressure and may elicit pain in the reference zone. "Trigger points" are found in various muscles in the shoulder girdle or back, and it seems likely that any muscles innervated by the spinal segments from the fifth cervical to the first thoracici may cause radiation of pain to the upper extremity. The vast majority of cases present between two and four "trigger points".

The muscles that most often cause pain in the shoulder region and arm are the serratus posterior superior. The "trigger point" is usually located in the upper lateral position of the muscle, and is partially covered by the scapula.

"For exposure the hand is placed in the opposite axilla, depressing the shoulder and flexing the spine. The referred pain is most intense over the long head of the triceps brachii at the posterior border of the deltoid and often extends to the entire triceps region and even along the ulner border of the forearm, the palms and the third and fourth fingers of the hand, the pectoral region and less frequently the spinous processes of the upper 2—3 vertebrae."

Next in frequency as a source of referred pain is the infra-spinatus. "The radiation of pain

is quite constant; it is most intense over the front of the shoulder and the long head of the biceps and may extend down over the entire biceps to the brachio-radialis."

Technique. 1-1½ per cent novacaine or ¼ per cent pontocaine without novacaine is used.

Procedure. The maximum point of tenderness is carefully located. This is done by putting the muscle on a stretch and by the use of pressure. Blind infiltration is usually ineffective. A small intradermal wheal is made and a sufficient amount of novacaine is injected to abolish pain; usually 2—5 cc. The muscle should be infiltrated slowly and little discomfort is experienced. Frequently an immediate sensation of heaviness, cold or numbness is noted.

Dosage. The amount injected at one time is usually 10-20 cc. of 1 per cent solution.

Reaction. In about 40 per cent of people a transient reaction of weakness, dizziness, constriction of the throat or thirst occurred.

Frequency. Patients may be injected daily to weekly. In addition, Vitamin C, 75-200 mg. per day. Local heat and encouragement of motion, complete relief of pain and limitation of motion is found in 60 per cent of cases. Improvement in 30 per cent.

NERVE BLOCK OR REGIONAL ANESTHESIA

Nerve Block anesthesia depends on one's knowledge of anatomy and infiltrating the nerve or an area immediately around the nerve with an anesthetic solution and thus removing pain from the area supplied by that nerve.

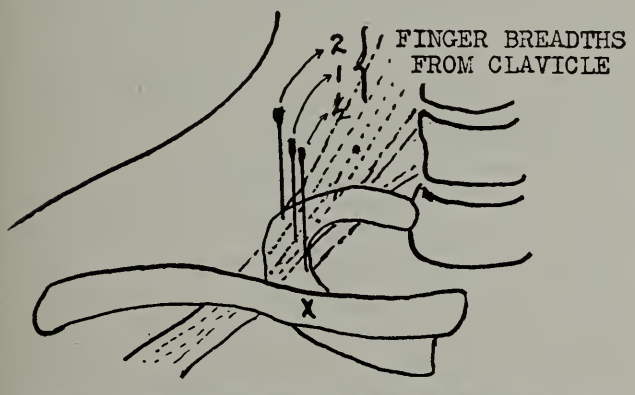


Fig. 8. Brachial plexus block as suggested by Dr. Ralph T. Knight, (Lundy's *Clinical Anesthesia*, W. B. Saunders Co.)

1. Brachial Plexus Block: Brachial plexus block is a very useful type of anesthesia which may be used in any type of operation involving the upper extremity. It is particularly valuable in suturing extensive lacerations in persons who have recently eaten and in whom a general anesthetic would be contra-indicated. Brachial plexus block may also be used under the following conditions:

(a) Amputation of hand, forearm or arm.

(b) Suturing of large lacerations as produced by shrapnel or in extensive phlegmons, arthroplasty, and plastic operations about the hand and forearm.

Technique. The patient is placed in a supine position with head slightly turned toward the unaffected side. The important land marks are the sternal notch, the point overlying the middle of the clavicle, the first rib, subclavian artery and the jugular vein.

A wheal is raised one finger's breadth above the middle of the clavicle and immediately lateral to the subclavian artery and external jugular vein. The needle is inserted through the wheal and down to the first rib. A second needle is inserted parallel to the first needle about one-half finger's breadth from the clavicle. A third needle is inserted parallel to the first needle and a finger's breadth posterior to it. Three to five cc. of 2 per cent novacaine solution is injected through each needle on to the first rib and seven cc. as the needle is slowly being withdrawn. It is then necessary to do a bracelet like injection around the arm near the shoulder for the purpose of blocking off any intercostal nerves.

2. Tibial Block. There are only two main nerves that supply sensation to the leg and foot.[5] These are the tibial and saphenous branch of the femoral. The saphenous is purely sensory and supplies a narrow area over the anteromedial aspect of the leg, for about half the distance from the knee to the ankle. It would be hard to block wih novacaine because of its variation. The tibial nerve divides into the posterior tibial and common peroneal. These are very definite and unvarying in position and can easily be found and injected. They supply all the muscles of the leg and foot and all sensation to the leg and foot except the small area supplied by the saphenous.

If the tibial and common peroneal nerves were completely blocked with novacaine an anesthesia of the muscles and skin would result in the foot and most of the leg, except that portion supplied by the saphenous nerve.

Technique. The patient is placed in a prone position on the operating table. The knee is flexed, flexion crease noted and skin prepared. A needle is inserted into the skin flexion crease behind the knee and at a point a little to the outside of the mid-line. The tibial nerve lies at this point. Five cc. of novacaine are injected just beneath the skin but not penetrating the deep fascia. This blocks sensation from the medial cutaneous branch of the tibial.

The needle is then inserted deeper without changing the location and pierces the deep fascia. The needle now lies in or just adjacent to the tibial nerve. Fifteen cc. of 2 per cent novacaine are injected.

The common perioneal nerve is constant and unvarying in its location as it winds around the head and neck of the fibula. A needle is

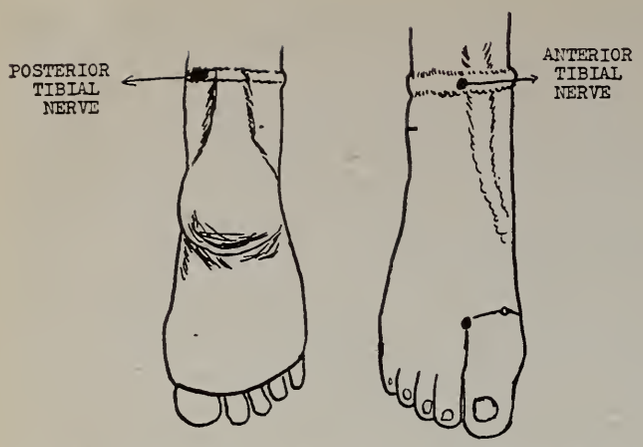


Fig. 9. A site of wheals for injection of local anesthetic, (Lundy's *Clinical Anesthesia*, W. B. Saunders Co.)

inserted on the lateral or posterior lateral aspect of the fibula just below the prominence of the head of the fibula and ten cc. of novacaine is injected.

a. Ankle Block. The most prominent points of the internal and external malleoli are palpated. An imaginary line is drawn between them. A skin wheal is made at the mid-point of this imaginary line. A 50 mm. needle is introduced through the wheal and the point of the needle is directed toward the anterior border of the internal malleolus. Paresthesia should be elicited and just before the needle strikes the tibia 10 to 15 cc. of 1 per cent novacaine or metycaine solution should be used. The posterior tibial is injected as indicated on the slide and the usual bracelet injection of skin and subcutaneous tissue. Anesthesia is present in about 20 minutes.

This type of anesthesia can be used for plastic operations about the foot such as repairing of the tendons, suturing of skin, etc.

3. Intercostal Block. Intercostal block is used for operations on the thorax such as rib resection, fractured ribs, etc. Premedication of morphine gr. ⅛ and nembutal are usually given. From three to five cc. of 1 per cent novacaine solution is deposited in the intercostal space near the inferior border of the rib. The technique is simple. If the fourth rib is to be blocked then a skin wheal is made over the fifth rib. The needle is then inserted directly down to the rib, this estimates the depth of overlying tissue. The needle is then withdrawn and angled up to the inferior border of the fourth rib where the solution is deposited. The point of the block should be between the site of the operation and the spinal column.

4. Block of Hand or Wrist Block. If it is desired to anesthetize the whole hand this can be conveniently done at the wrist. A ½ per cent solution of novacaine or metycaine is injected in bracelet fashion around the wrist. Then the radial, medial and ulnar nerve are sought. Two methods of locating them are possible:

a. The anesthetist places his three fingers on

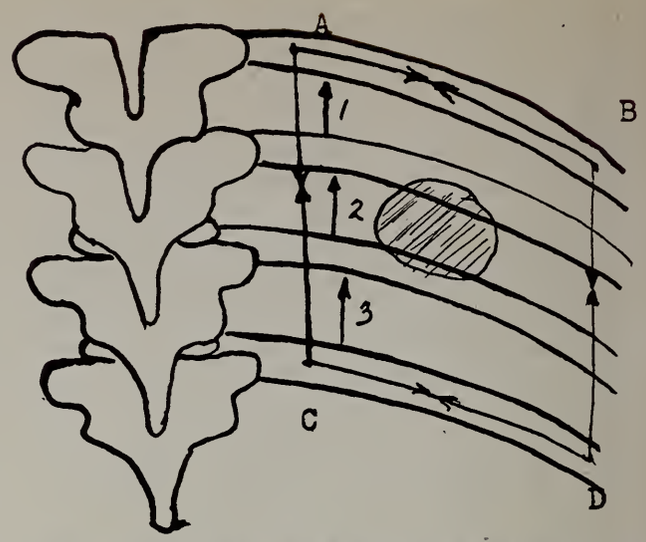


Fig. 10. Intercostal and field block operation on the chest. Intercostal block is carried out as indicated by arrows 1, 2, and 3; 3 to 5 c.c. of 1 per cent solution of procaine or metycaine are injected against the intercostal nerves near the lower borders of the overlying ribs. Field block is accomplished by injecting intradermally and subcutaneously down to the rib, a to b, c to d and a to c; finally, injecting b to d.

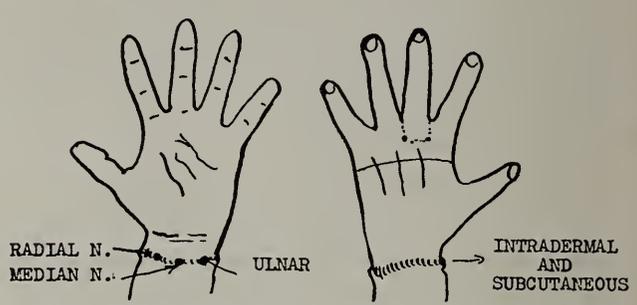


Fig. 11. Block Anesthesia of the hand; wrist block, intradermal and subcutaneous injection as a bracelet around the wrist, including block of the radial, median, and ulnar nerves. From Lundy's *Clinical Anesthesia* (W. B. Saunders & Co.)

the volar surface of the wrist, the middle finger being on the median line of the wrist. The nerves underlie these fingers.

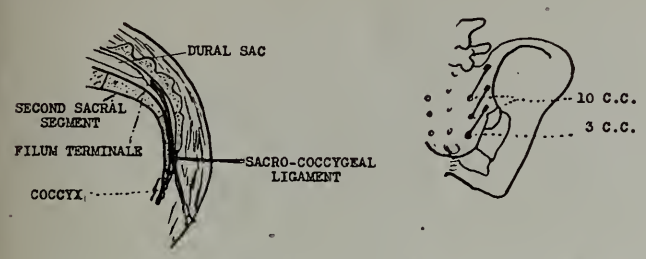
b. The hand to be anesthetized is flexed so that the two tendons, the palmeris longus tendon and the flexor carpi radialis, are prominent.

A very fine needle is introduced between them through the skin wheal. A mild fibrous resistance is encountered—the brachial fascia. Once this resistance has passed the needle is inserted three to four mm. deeper and from three to six cc. of 1 per cent novacaine solution is injected. The ulnar nerve lies just above the ulnar styloid process. Again the needle is inserted through the wheal and down to the styloid process and from three to six cc. of 1 per cent novacaine solution is injected. The same technique is used for the radial nerve. Wrist block usually gives two hours anesthesia.

5. Caudal. Caudal and transacral block are really forms of regional anesthesia, in which insensibility to pain is produced by injecting local anesthetic into the sacral canal through the sacral hiatus.

This method is extremely useful for opera-

tions about the pelvis, perineum, rectum and anus. The procedure has been popularized by Robert A. Hingson, James P. Southworth and Waldo B. Edwards for use in obstetrics. Since this is not an office procedure we will only mention its use.



Caudal anesthesia is very useful in the aged, debilitated and those subject to shock. Caudal anesthesia has all the pain removing properties of low spinal, but in addition there is no motor paralysis, post spinal headache, and very little if any fall in blood pressure.

Some office procedures caudal anesthesia may be advantageously used in are:

1. Open or closed reduction of fractures of the lower extremity.
2. Phlebectomy and ligation of varicose veins.
3. Cystoscopy and transuretheral resection.
4. Circumcision and procedure involving the bladder.
5. Hemorrhoidectomy and fistulectomy and plastic operations about the rectum.
6. Any gynecological surgery of the external gentalia such as Bartholim cyst or cervical repair such as cauterization, or conization, etc.

Possible complications are:

1. Spinal injection.
2. Reactions to novacaine and its related compounds.
3. Infection.
4. Broken needles.

However, these are breaks in technique or idiosyncrasy to a drug and do not necessarily condemn the procedure.

SUMMARY

An attempt has been made to show techniques which are valuable to you as physicians in:

1. Alleviating pain.
2. Returning a patient to industry as soon as possible.
3. Relieving already overburdened hospitals of minor surgery which can become an office procedure. For example, circumcisions, hemorrhoidectomies, Bartholin cysts, etc.
4. The drugs used may be novacaine, in strength ½ to 2 per cent; pontocaine, ¼ to ½ per cent; and sarapin, full strength. The effect of sarapin last from several days to several months and is especially useful in back injuries and chronic myalgias.

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Preventive Aspects of Coronary Disease

For hundreds of years the medical profession has approached the problem of the treatment of arteriosclerosis and the other degenerative diseases with comparative hopelessness. In this paper it is proposed to call attention to the fact that a certain number of cases of coronary disease—or, more properly, myocardial infarction—have preventive aspects; that once the attack has occurred, death may sometimes be averted; but, most important of all, to emphasize that one must approach an important field in preventive medicine with hopefulness rather than despair. In short, our attitude toward this disease must keep abreast of our newer concepts of its physiology and pathology.

About two years ago, when this study was started, some of our colleagues were skeptical of the idea of coronary disease having preventive possibilities. Yet we have been treating angina pectoris since the days of Heberden in 1768, and even before, from a prophylactic point of view. What else have we been doing when we advise the anginal patient to restrict his activities, to keep calm, to avoid tobacco, to keep his weight down, to take an occasional drink of whisky? It is true that we have been trying to reduce the severity of the individual attack but, consciously or not, we have felt that we could prolong his life; in other words, that we could postpone the day, which we felt would inevitably come, when his life would be cut short by coronary disease.

The first important consideration is that there are certain people who are especially likely to have coronary artery disease and that these are the ones who must be specially guarded by their physicians. In the present state of our knowledge we have no way of being sure which people already have damage in the coronary arteries. Even the electrocardiogram, which is our most valuable guide, measures not the changes in the coronary arteries but what takes place in the heart muscle. Nevertheless, there is some degree of predictability and it is statistically certain that some people are more vulnerable than others.—Milton Plotz, M.D., Brooklyn; N.Y. State Jour. Med. Vol. 44, No. 11, June, 1944.

Plastic Shelf Operation for Dislocated Hips

FOWLER B. ROBERTS, M.D.

CONGENITAL dislocation of the hip has been recognized since the time of Hippocrates but no success in the treatment of this condition was achieved until the early part of the nineteenth century. Until this time it had been considered an incurable condition to be treated only by palliative measures.

In 1826 Dupuytren aroused new interest by publishing his pathological findings in which he said, "This displacement consists in a transposition of the head of the femur from the cotyloid cavity on to the external iliac fossa, a transposition which exists at birth and which appears to be a defect in the depth and completeness of the acetabulum rather than to accident or disease." He also felt that this condition was incurable, but his work became well known and was followed by the development of several forms of manipulative reduction leading up to the work of Paci, Hoffa, and Lorenz in the later part of this century.

While there seems to be little doubt that Paci developed the closed method of reduction several years (1888) before Lorenz (1896), yet, due to certain circumstances, and probably better salesmanship on the part of Lorenz, his name has become synonymous with the closed reduction. Then, as today, manipulative results were most successful in the younger patients. After the age of three the number of failures increased in direct proportion to the age of the patient due to bony deformity of the head and acetabulum and contractures of the surrounding ligaments and muscles.

Correction of the bony defects was first attempted by subtrochanteric osteotomy and of the soft tissues by tenotomies, but not until late in the century was the joint itself attacked surgically. Resection of the hip joint for diseased conditions was being tried about this time and so was also tried for this condition. This met with little success because what was gained in deformity correction was lost by the instability which resulted.

RECONSTRUCTION SURGERY

In 1880, Poggi in Italy apparently was the first to attempt any reconstruction surgery, by cleaning out and deepening the shallow acetabulum, attention to which had been directed by Dupuytren some 50 years before. He developed the first of the three major advances in the technique of reconstruction surgery of the hip. Shortly after Paci's report, Hoffa of Berlin published a similar technique. During this same period the closed method of reduction was gaining wide favor and overshadowed the surgical procedures probably because of the large percentage of infections following open surgery. However, in 1891, König described the second important advance in technique by developing the use of a bone "stop" or "block" which was the first of the so-called shelf operations.

This consisted in turning down a flap of bone from the side of the ilium to increase the depth of the acetabulum. This method of increasing the acetabular depth was a much better concept, because it did not destroy the remaining articular cartilage which might be present in the acetabulum and thus decreased the possibility of ankylosis following operation. This concept was widely accepted and has been the basic principle in all shelf operations since that time. However, no single technique was accepted for performing this, which showed that there was still some basic principle for the ideal reconstruction of the acetabulum which had been overlooked in the various techniques. All of these techniques fall into two general groups: Those which use some type of bone peg taken either from the adjacent bone, or from the tibia, as represented by the techniques of Pemister, Compere, Ober, and Ryerson; and those which use some form of bone flap turned either upward or downward from the side of the ilium, over the acetabulum outside the capsule as represented by the techniques of Dickson, Gormley, and Lowman.

To produce the ideal plastic reconstruction of the hip, the following should be accomplished. The new portion of the acetabulum should continue the arc of the circle which is found in that portion of the acetabulum already present, and this should be smooth and regular in its contour. The side of the ilium directly above the new acetabulum should approach the same contour as the same area on the opposite side. The capital epiphysis should approach the same degree

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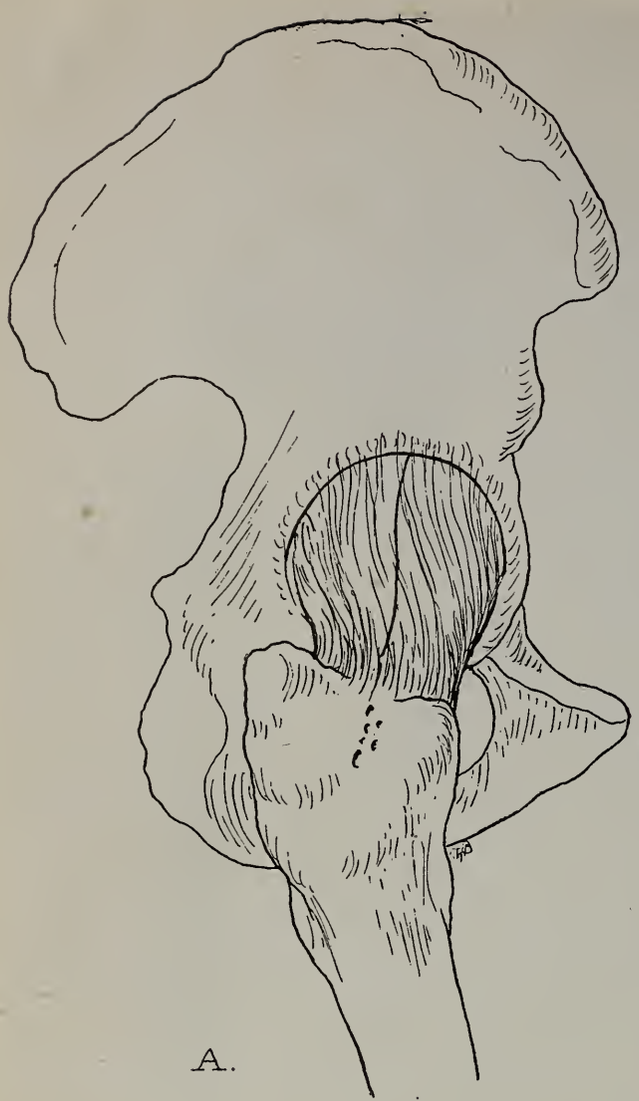
Figure 1. Roentgenogram showing a typical high riding dislocated hip in a child of three years.

of development as the opposite side and should not be distorted in form. There should be no increased space between the head and the acetabulum producing a Trendelenburg sign.

This first type of technique fails to meet any of these requirements; because, the pegs do not conform to the shape of the head thus continuing the natural arc of the acetabulum, and produces greater deformity of the head. They also tend to form a spike-like protrusion above the head instead of a smooth buttress, and do not fit snugly enough above the head to prevent a Trendelenburg.

The technique which turns the flap outward from below is open to much the same criticism, but primarily in reference to the irregularity of the under surface of the shelf and its resultant effect upon the growth of the head. When the flap is turned down from above, it theoretically should fulfill all of the above requirements but has failed to do so many times because of lack of proper molding of the flap to the contour of the head and its fixation in that position. It is this molding of the bone flap to the contour of the femoral head and its positive fixation in that position which I believe is the third important step in the development of this operation.

Albee complained that too many of these cases had a Trendelenburg sign after healing. Hass attempted to overcome this migration of the flap upward by placing Steiman pins directly above the head into the rim of the acetabulum. Kidner called attention to the importance of stripping the capsule from the side of the ilium so that the head could be brought down to its normal level and the flap made directly above.





Nearly all writers on this subject stress the importance of maintaining traction on the leg for some time after the operation to prevent a displacement of the flap upward.

Lowman used a suture through the outer border of the bone flap and into the capsule below to prevent such displacement. Gill, in 1928, discussing his Type II cases, made the following statement: "The capsule is brought up over the flap which has been turned down but it cannot be sutured in any fashion."

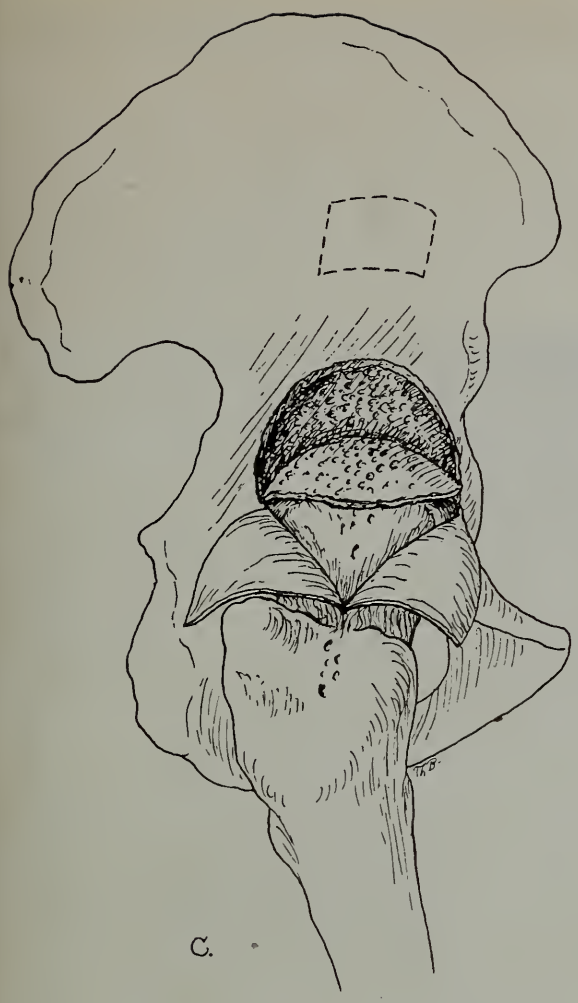
THE TECHNIQUE

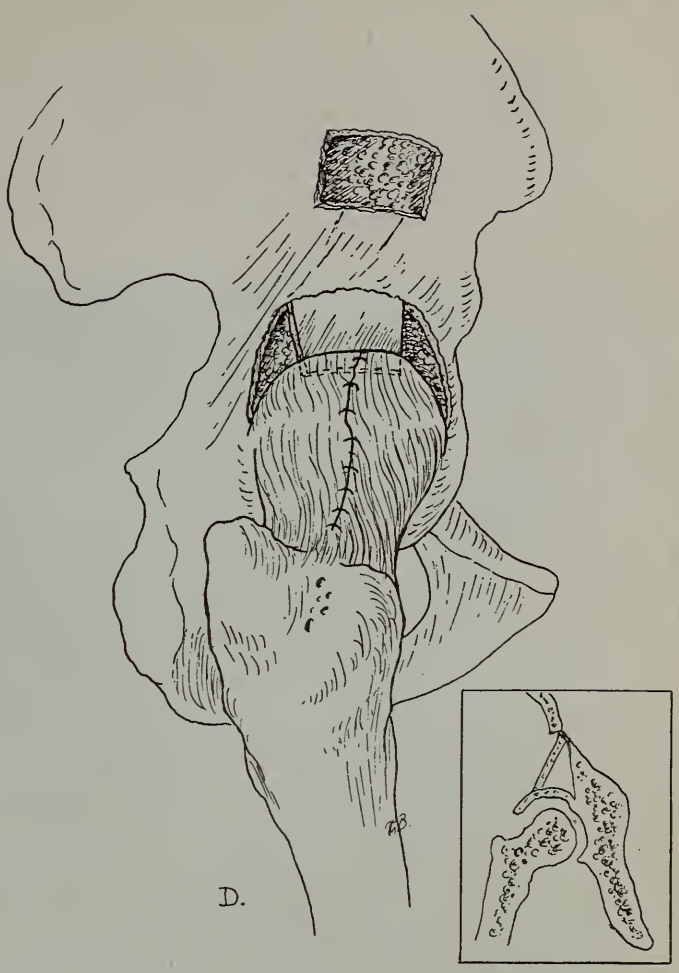
The technique to be described here was developed several years ago and at that time the author was unaware of the statement just quoted from Dr. Gill's article. This was the only reference found where the bone flap was placed beneath the capsule directly over the head.

The technique used by us is as follows: After a 48-hour skin preparation an ilio-femoral incision is made using the technique of Smith-Peterson. The muscles on the side of the ilium are stripped forward and backward with the periosteum far enough outward so the capsule is exposed well down to the eight and four o'clock positions. If the capsule is adherent above the acetabulum it is separated from the bone by both sharp and blunt dissection making no effort to completely remove all the fibrous tissue from the bone just above the rim of the acetabulum.

A longitudinal incision is then made beginning at the rim of the acetabulum, and extending the full length of the capsule directly above the neck of the femur. Two incisions in the capsule are then made beginning at the upper end of the previous incision and extending outward along the rim of the acetabulum to the three and nine o'clock positions (Fig. A). The corners of these flaps are caught by heavy Allis forceps and drawn outward as one would quarter the skin of an orange (Fig. B). The head and acetabulum can then be readily inspected. In most cases, the head can be brought down to its normal position without difficulty at this time.

If there is any normal cartilage in the acetabulum it is not disturbed. However, if the acetabulum is very shallow and filled with fibrous connective tissue, a portion of this is removed, but not to such a degree that raw bone will be exposed. A semi-circular cut is then made in the





ilium directly above the acetabulum beginning at the nine o'clock position a short distance from the edge of the acetabulum. This cut is curved upward and around the acetabulum to the three o'clock position with the width the same as at the nine o'clock position, the greatest width of the flap being at the twelve o'clock position, and at this point of such a width as will make the proper depth of the new acetabulum.

The base of this flap is, as nearly as possible, exactly at the old rim of the acetabulum. The outer cortext of the ilium with a small portion of the cancellous bone only, is used for the flap, and is turned out gently so that it is molded neatly to the contour of the femoral head (Fig. C). The younger the patient the better this can be accomplished. When this flap is in position the capsule is then replaced with its edges coming up over the outer edge of the bony flap, and sutured in position with chromic catgut. After this has been done the traction on the leg can usually be removed and there will be no upward riding of the femoral head.

From the side of the ilium a rectangular piece of bone is then removed, using the full thickness of the ilium, and making the rectangle of such a size that it just fills in the space between the outer edge of the bone flap and the side of the ilium from which this edge was turned down. This strutt is tucked under the edge of the capsule and under the edge of the outer table of the ilium (Fig. D). The muscles are then dropped back into position and the wound closed in the usual manner.

Sterile dressings are applied to the wound and a long hip spica immediately made. No traction of any kind is used. This cast is left on for eight weeks at which time it is bi-valved and an X-ray made. The treatment from this point on depends entirely on the regeneration of the bone at the site of the new acetabulum.

THE RESULTS

We have used this technique successfully in cases up to six years of age. **(See pages 654, 655 and 656 for roentgenograms on selected cases).** Wherever the head can be brought down to, or near, its normal level, we have had no real difficulty in suturing the capsule over the outer edge of the bone flap. In all cases where the X-ray shows the acetabulum to be of such a depth that it seems probable that it will retain the head, the closed method is used. If, however, at any time during the course of treatment it is found that the head is beginning to re-dislocate, then an open reduction with a plastic reconstruction is done. In those cases where the acetabulum

(Continued on page 656)



Figure 2. Roentgenogram showing the immediate post-operative condition with the head of the femur down opposite the center of the acetabulum and also the substantial buttress formed by this operative procedure. Child was five years of age at the time of operation.

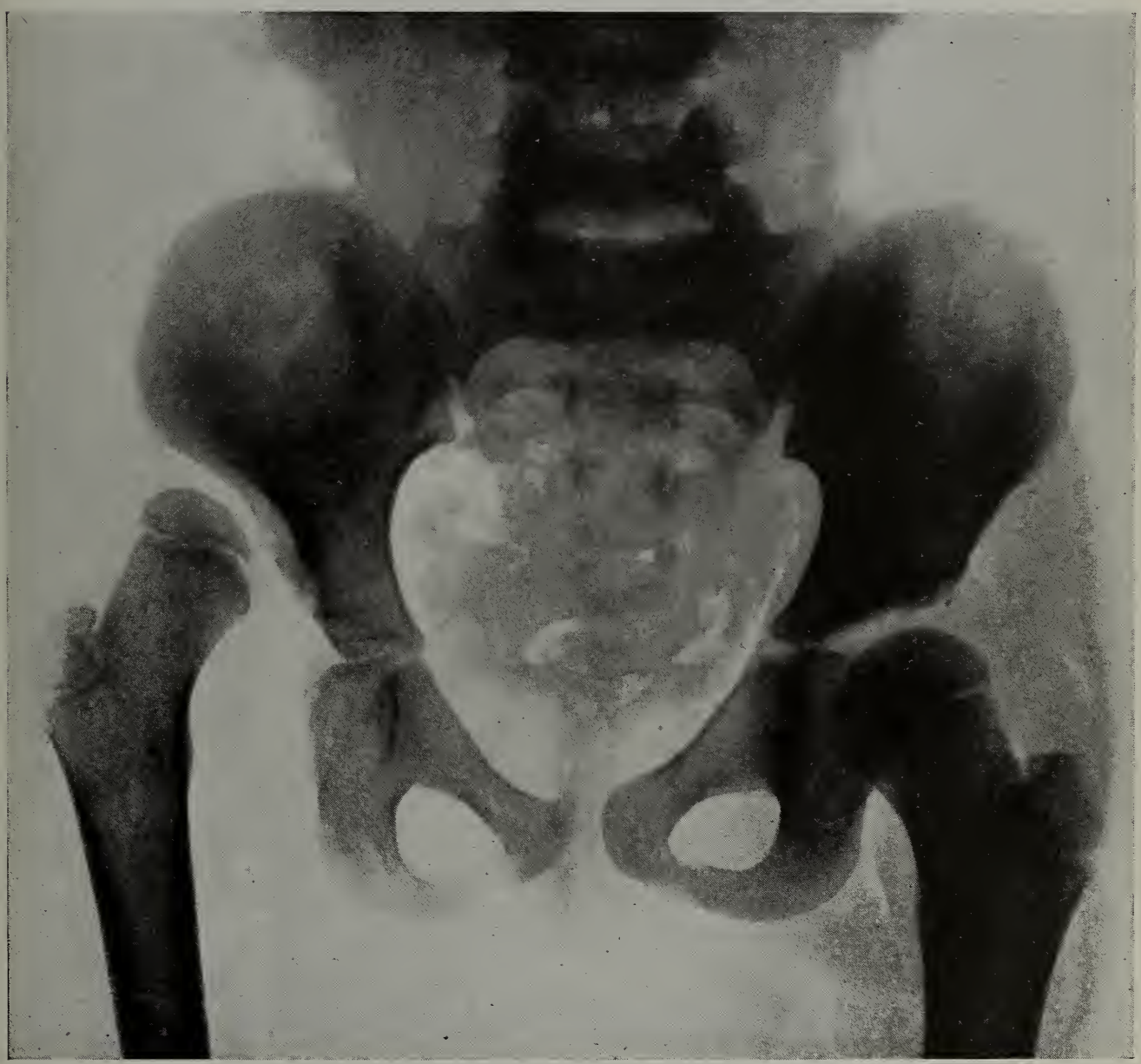


Figure 3. Roentgenogram demonstrating a high riding dislocated femur in a child six years of age.



Figure 4. This is a picture of the same case as in Figure 3, seven months after operation, demonstrating the well formed new acetabulum. In this case it will be noted that the head of the femur is somewhat higher than normal. This is due to the fact that at the time of operation it was not possible to bring the femur down as low as would be desired. In spite of this a perfectly satisfactory acetabulum has been obtained.

is so shallow that it is obvious that the head will not be retained in the acetabulum, an open reduction is done immediately following the preliminary traction.

While the age of the patient and the position of the head per se are no contra-indication for using this technique, it is, however, true, that the best results with the nearest approach to a normal anatomical end result will be had in the younger patients. I am inclined to agree with Dr. Gallaway that the ideal age for this procedure is from 18 to 24 months. At that age there is the least distortion of the head and capsule and the bone is more pliable and so more easily molded to the desired contour.

In conclusion—We make no claims for developing a new technique for the plastic reconstruction of the acetabulum, but we do believe that the third important step in this technique, first described by Dr. Gill, has been very much neglected, and we wish to commend it to you as a most useful and satisfactory procedure.

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Bilateral Renal Carcinoma*

MORTIMER LUBERT, M.D.

Case History. The patient, a 52 year old white coal miner, entered City Hospital of Cleveland with the chief complaint of inability to urinate. By straining he could pass a small quantity of blood. One month prior to this he experienced a brief episode of hematuria which he ignored. Other urinary symptoms were inconsequential. Following a rectal examination his retention disappeared and he passed grossly bloody urine for a short time and then resumed normal urinary habits.

Physical examination was not contributory. Some blood was present at the urethral meatus and the prostate was symmetrically enlarged but of about normal consistency.

Laboratory examinations revealed blood in the urine only in the earlier specimens. There were 4,950,000 red blood cells and 6,000 leucocytes per cu. mm. of blood. The blood urea nitrogen was 16 mg. per 100 cc. of blood.

Retrograde urograms showed distortion of the middle and upper calyces of the right kidney but no abnormalities of the left kidney. The chest film revealed a symmetrical nodulation in both lungs. The diagnoses were tumor of the right kidney and pulmonary silicosis.

On Nov. 2, 1937, a right nephrectomy was performed. On Nov. 17, 1937, a course of high-voltage roentgen therapy was administered. The following physical factors were employed: 200 k. v., 0.75 mm. Cu and 2.0 mm. Al filtration, 20 m. a., 70 cm. T.S.D. and 300 r to one of three fields (13 x 11 cm.) daily until 2100 r had been given to each field in 21 days. The patient withstood the therapy well and was discharged Dec. 1, 1937.

The removed kidney weighed 180 Gm. and in it there were two encapsulated nodules which measused 2.5 cm. and 1.5 cm. in diameter. Several smaller nodules measuring up to 0.5 cm. were also present. These were closely grouped in the midportion of the kidney involving cortex and medulla. One of them had invaded the renal pelvis. Histological examination showed the presence of solid masses of clear cells with areas of necrosis and hemorrhage. The pathological diagnosis was clear-cell carcinoma of the right kidney.

The patient was readmitted to the hospital Sept. 29, 1943, with the chief complaint of persistent cough and expectoration. No genitourinary complaints were elicited. Following an adequate investigation, he was discharged with the diagnoses of silicosis and recent pneumonia.

The third and final admission occurred Jan. 14, 1944, when the patient again had difficulty in urination. This quickly progressed to anuria which was not relieved by catherization.

Limitation of motion and retraction were present in the lower portion of the left side of the chest. The left kidney was enlarged and tender.

Examination of the blood showed 70 per cent hemoglobin (Sahli) and 9,200 leucocytes per cu. mm. No urine could be obtained. The blood urea nitrogen was 86 mg. and the creatinine 10.8 mg. per 100 cc. of blood.

Roentgenograms revealed atelectasis of left lower lobe and an enlarged left kidney. Retrograde urograms did not show calyceal or pelvic deformity.

The patient was treated by ureteral catheterization and intravenous fluids to combat acidosis and promote diuresis. He remained anuric, became comatose and died 5 days after admission.

Autopsy. The left kidney weighed 510 Gm. Only the upper portion of the left kidney, estimated at one-third the original volume, appeared normal. The remainder was almost entirely displaced by a large lobulated tumor, some of the nodules of which were soft and cystic and others firm and compact. They varied in size from 1 to 4 cm. and in color from grayish-yellow to dark red. On section the dark red nodules were hemorrhagic and their substance was friable. The grayish-yellow nodules were solid and homogeneous. The renal pelvis, ureter and large blood vessels were not involved. The lower lobe of the right lung contained several nodules, none of which was larger than 3 mm. in diameter. One of the nodules invaded a secondary bronchus. A diffuse black nodulation was present throughout the lungs and the lower lobe of the left lung was small, black, fleshy and lacked aeration. Some of the bronchi in this lobe were dilated. The hilic lymph nodes were enlarged, black and rubbery.

Histologic examination showed a solid clear-cell carcinoma of the left kidney with several small metastases in the lower lobe of the right lung. In the former, evidence of recent and remote hemorrhage was found. The microscopic appearance of the tumor of the left kidney was identical with that found in the right kidney extirpated 6 years previously.

The principal pathologic diagnoses were clear-cell carcinoma of the left kidney, the seat of necrosis and recent hemorrhage, with metastasis to the right lung; silicosis; atelectasis, fibrosis and bronchiectasis of the lower lobe of the left lung; remote right nephrectomy.

COMMENT

In a case of bilateral renal carcinoma two points of view may be entertained. The first is that the carcinoma is primary in one of the kidneys with metastasis to its fellow. The second is that each is the site of an independent primary renal tumor. The choice between the two is not easy nor is either interpretation entirely satisfactory. Certain criteria,[1,2] however, have been proposed and these are of value in deciding which view is more likely in a particular case.

According to Billroth unequivocal examples of double primary tumors must have separate points of origin, different histologic characteristics, and give rise to distinctive metastases.

*Selected by H. T. Karsner, M.D., from the Clinical-Pathological Conferences at Cleveland City Hospital as the twenty-first of a series of cases to be published under the heading "Case Records Presenting Clinical Problems".

Other observers[1,2] believe these requirements too exacting when each of a pair of organs is involved. In such instances other criteria have been proposed. If the tumor in each of the pair of organs has the gross appearance of a primary neoplasm and if there is considerable variation in the histological character of each tumor both in structure and type of cells, such tumors may be considered primary. These points receive considerable reënforcement by the absence of metastases elsewhere, since it is extremely unusual for a renal tumor to metastasize exclusively to the opposite kidney.

Some of the evidence in the case presented here favors the presence of double primary renal tumors. The lesion in each kidney had the appearance of primary renal carcinoma. Metastases elsewhere were extremely small and were limited to one lobe of the lung. Preoperative urograms revealed no abnormalities in the opposite kidney. The initial therapy, consisting of nephrectomy and x-irradiation, freed the patient of local or systemic evidence of carcinoma for six years.

Against this conception, however, these points must be considered. The appearance of the tumors in either kidney, while resembling a primary neoplasm, is not inconsistent with that of metastasis. Especially is this true of the extirpated kidney which had multiple discrete nodules of tumor. The latter, of course, necessitates the interpretation that the first clinical evidence of the carcinoma was the result of a metastatic lesion and that the primary tumor remained clinically silent for at least six years. Both these facts are consistent with the known behavior of kidney carcinoma. The fact that the original urogram did not show the primary tumor in the remaining kidney is not inconsistent with occasional radiologic and urologic experience.

The presence of tumor in the right lung, though limited in size and distribution, demontrates that a propensity to metastasis was present. The histologic appearance of the tumors in the kidneys was similar and each lacked variation within itself. This is in favor of a single primary tumor with metastases. Yet, it does not aid in determining which kidney is the site of the primary tumor.

Beilin and Neiman[1] and Forsythe[3] in separate reports collected 8 and 6 cases of double primary renal carcinomas respectively. The larger series did not include all the cases in the smaller series and each reported an additional case. Many of the collected cases in both reports did not meet even the less exacting set of criteria set forth above.

CONCLUSIONS

(1) An unequivocal diagnosis of double primary renal carcinomas is difficult to make both clinically and pathologically. (2) There is considerable doubt as to the validity of the diagnosis in many of the cases presented as such in the literature.

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Preventive Therapy

A paradox of therapeutic medicine is the enormous amount of care and thought given by the physician to the patient with symptomatic heart disease—to gain some months or a few years of life, often uncomfortable—in comparison with the relatively little attention paid to the patient with asymptomatic heart disease—when a prize of many added, comfortable years may be the result. A moment's reflection will bring to mind the common case of established hypertension without heart disease, mitral stenosis without signs or symptoms of congestive failure, the asymptomatic patient who has recovered from a coronary closure, etc. It is upon this type of patient that far too little attention has been focused.

It is not sufficient merely to establish the diagnosis and advise restriction of activity. Indeed, the wisdom of restriction of activity is open to question in many cases. Thus, one medical journal in a single issue describes the case of a patient with aortic regurgitation and mitral stenosis handling the position of a champion marathon runner for years with ease and the case of a man recovered from a typical coronary closure flying at altitudes up to 15,000 feet, dancing, swimming, and skiing each winter at altitudes up to 10,000 feet—all being accomplished without detriment. Such individuals are numerous and should not be penalized by the physician who restricts the activity of all who have heart disease. Unfortunately there are no universal rules to apply which are recognized. This, perhaps, need not be so, and the situation would appear to be a distinct opportunity for those physicians who know their patients intimately and follow them for many years to formulate such rules. Such a problem cannot be solved, apparently, either in the hospital or laboratory.—William J. Bruckner, M.D., New Haven; Conn. State Med. Jour., Vol. VIII, No. 6, June, 1944.

Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

PREGNANCY IN ADVANCED TUBERCULOSIS

The clinical onset of tuberculosis in many women is associated with pregnancy. Since collapse therapy has improved the chances of the tuberculosis patient in general, re-evalution of the effects of pregnancy upon the disease was undertaken. A selected group of 26 patients with tuberculosis, treated with various types of surgery, was observed before or during pregnancy. The average period of clinical and roentgenologic observation was 9 years, during which 40 children were born of whom 36 were alive and well. Nine other pregnancies terminated prematurely. Tuberculosis was confined to one lung in 15 patients. In 11 it occurred in both lungs. Of the 26 cases with an effective collapse, only four showed an unsatisfactory course during pregnancy or following childbirth and of these, three later improved, the fourth had a spontaneous abortion. In three patients in whom collapse therapy was not satisfactory, there was a reactivation following childbirth.

In patients in whom the diseased areas of the lung are anatomically well collapsed, tuberculosis will not become active in pregnancy. Phrenic nerve interruption alone is inadequate. Physiologic, social and pathologic factors should be considered before determining the hazard of pregnancy but the safest interval for a tuberculous woman to have children is during the period of effective collapse therapy.—The Harmful Influence of Pregnancy on Advanced Tuberculosis as Modified by Collapse Therapy, J. W. Cutler, M.D., Amer. Jour. of Obstetrics and Gynecology, January 19, 1944.

TUBERCULOSIS AND PREGNANCY

Type of Delivery. When delivering a woman with active pulmonary tuberculosis the severity of the illness and the extent of the lesion must receive consideration. The internist or phthisiologist must be responsible for the tuberculous condition during confinement just as he has been during pregnancy.

It seems good obstetrics to allow these women to come to term and deliver naturally. However, to induce labor ten to fourteen days early, when the condition of the patient permits, saves time when the load of pregnancy is greatest. The doctor should be liberal with analgesia during the early stages of labor and supportive treatment is necessary. The main points I wish to stress are relieve pain, conserve energy, save blood and support the patient.—E. P. Allen, M.D.

Care. The most important thing during the puerperium and the months following is to treat the tuberculous disease. If the disease is under control, the outlook for the future is good. If in spite of therapy the disease progresses the prognosis is bad. The future destiny of the pregnant tuberculous female is dependent upon the character and the control of the tuberculous disease.—George G. Ornstein, M.D.

Indications for Abortion. Labor should not be induced in a case of pregnancy past the 28th week. In the rapidly progressive caseous type of tuberculosis, abortion should be avoided in the interest of the fetus. Where recovery from tuberculosis is highly probable, abortion should be done if the pregnancy has not advanced beyond the 12th (possibly the 16th) week. In other types of cases no rules can be formulated. Judgment must be based upon an adequate knowledge of the determining factors in each case. Conservation of pregnancy is usually safer than therapeutic abortion.—Willard R. Cooke, M.D.

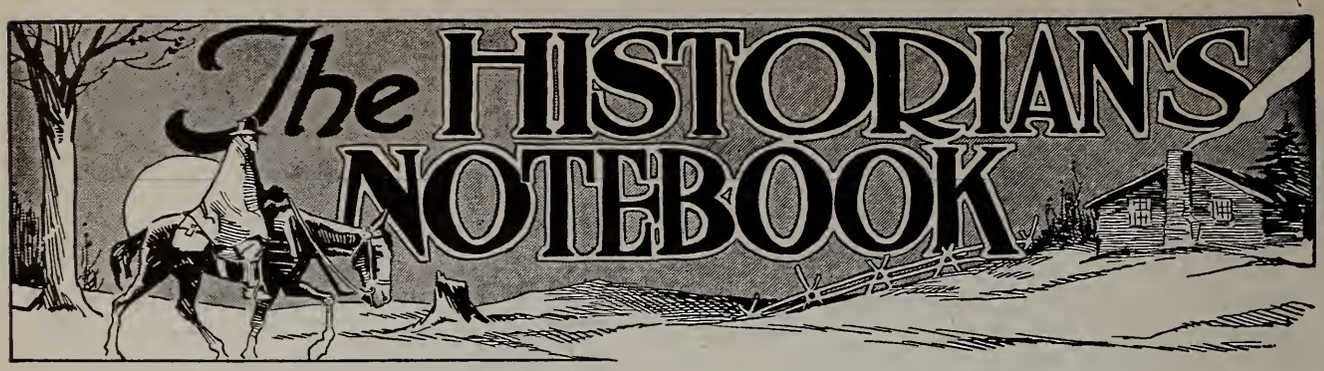
Should She Bear Children? The average woman with arrested tuberculosis is a desirable candidate for motherhood. She has been physically tested and psychologically disciplined by disease and will cooperate intelligently. There should be a period of about two years following arrest before it is safe to consider bearing a child. Consideration must be given to the economic situation of the prospective mother. Only the best of care and freedom from domestic responsibility will suffice to keep her well following delivery.—Lewis J. Moorman, M.D.

From a Symposium on Tuberculosis and Pregnancy, Transactions of Natl. Tuber. Assn., 1941.

Fatigue spans the arch between health and disease. We know that artificially exhausted animals are more susceptible to pneumonia—that tuberculosis is in part a fatigue problem. —M. Z. Gross, Hygeia, October, 1942.—NTA Clip Sheet.

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Tuberculosis is a social problem with a medical aspect.—Sir William Osler.—NTA Clip Sheet.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

National Hospitals in the Valley of the Mississippi

Cincinnati, October 1, 1834.

IN a late number, we penned a few sentences on this subject, suggested by Dr. Campbell of St. Louis, and promised to resumé it. The want of hospitals for the reception of those engaged in the laborious, unhealthy, and dangerous navigation of the Mississippi and its great tributary rivers, has long been felt. Impressed with this sentiment, the legislature of Louisiana, about the year 1819, proposed to the Mississippi states, to establish hospitals, in different places, and give to their citizens, in distress, reciprocal admission. But little, as far as we know, grew out of this suggestion. However, the legislature of Ohio, early in 1821, on the recommendation of Governor Brown, followed up by their personal application of the Editor of this Journal, instituted and endowed in this city, the existing charity, denominated the Commercial Hospital of Ohio; and some years afterwards the people of Louisville, aided by the state of Kentucky, established another in that place—provision of a similar kind having, meanwhile, been made in New Orleans. But these establishments, so far from supplying the wants of the great valley, have only served to render them more apparent. With the increase of population and commerce, spreading themselves up and down every stream that can float the humblest steam boat, the number of patients has been multiplied a thousand fold, since those hospitals were erected, and the points which call for similar establishments, increased in the same ratio. To comprehend the magnitude of our wants in this respect, we must glance at our actual condition.

The number of inhabitants, dependent more or less upon the Mississippi, as their great channel of communication with the ocean, is about 4,000,000. In descending, the river with the produce and manufactures of western Pennsylvania and Virginia, Ohio, Indiana, Illinois, Missouri, Kentucky and Tennessee, to say nothing of Alabama, Mississippi, Arkansas and Louisiana, those engaged in the trade, go from a higher to a lower latitude; and as this commerce is chiefly carried on in the spring, early summer, and beginning of autumn, they are often exposed to great heat, and to all the causes of disease, which heat and moisture, acting on dead vegetable matter, can generate. The casualties of the river, moreover, are numerous and unavoidable—such as boats getting aground and compelling the boatmen to expose themselves to "fire and water" in the rays of a burning sun and the current of the stream—the snagging and sinking of boats, and consequent lying out at night—the bursting of boilers, and aspersion of steam and hot water, over the crew and passengers—finally, the crash of boats against each other at night, by which the limbs and even lives of those who navigate them are often mutilated or destroyed. In these and other modes of smaller violence, a very great number of sick and disabled persons are constantly floating on our rivers, or left to perish (if nature should not save them) in cabins on the shore. Among these sufferers, are not a few who are persons of consequence to society, and have left respectable families, thus to perish on the river, or beneath the deep forests, which casts their gloomy shadows on the surface of its waters.

Such being the state of the interior, it is undeniable, that both humanity and patriotism call aloud for the establishment of houses of reception and relief, at so many different points, as to permit the sufferers from accident or disease, to be landed in due season, and treated with skill and

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This editorial by Dr. Daniel Drake appeared in "The Western Journal of Medical and Physical Sciences". Drake was the founder of the Medical College of Ohio and for forty years was the most influential medical figure in the Ohio Valley.

kindness. We shall not undertake to designate where these hospitals should be placed, or even to suggest the number that are required, as this could only be done by a commission of experienced river traders and intelligent steam boat masters, with whom we shall leave the subject, and proceed to inquire by whom they should be erected.

The benevolent proposal of the state of Louisiana has not been successful; and, indeed, it cannot be expected that any public work, which requires the co-operation of eight or ten states, can be executed, except by the federal government. That government was instituted by the people of the states, expressly to perform such enterprises as would otherwise require the co-operation of several; and it is not, indeed, compatible with the integrity and quiet of the Union, for groups of states to go into special compacts. In this instance, it is true, no harm could come from such a subordinate confederacy, as whatever cements the Mississippi states more closely, tends to hold the Union together; but still it would be a violation of principle and the general government should prevent such a step, by itself executing the work—we should rather say **national** work. That it would be as strictly and legitimately a national work, as any connected with the seaboard, and having for its object the promotion of the commerce of the country, will be admitted by all who may have the industry to examine it, and the candor to state the result of their inquiry.

We do not need fortifications, artificial harbors, light houses and breakwaters, in the interior, but we want commercial hospitals. Let it not be said, that the trade which renders them necessary, is merely a traffic between the people of the same state, or even of different states. It is a part of the great foreign commerce, exporting and importing, of the United States; and deserves to be fostered by the general government, not less than that which floats on the ocean. The relation between the interior and New Orleans, is not that of mere supply and consumption, but of supply and transmission. The produce of the most productive, if not quite the most extensive valley on earth, is concentrated at the mouth of the river, for shipment and distribution over the Atlantic states, the West Indies, and the kingdom of western Europe; and has already been started on the great voyage to distant lands, when it is embarked at Pittsburgh, Cincinnati, Louisville, St. Louis, Nashville, or any of the hundred intermediate towns of lesser note.

But why do we confine our observations to the Valley of the Mississippi? The Basin of the Lakes has equal wants in this respect, and the whole should be embraced in one system. The coast, along which an active trade is already carried on, extends from near the eastern end of Lake Erie, to the western shore of Michigan—from Cleveland to Chicago and Green Bay—embracing the northern frontier of Ohio, Michigan, Indiana and Illinois, and stretching out, when we follow its sinuosities, more than a thousand miles. As this coast is that of inland seas, which separate the United States from a foreign government, it is as much entitled to the fostering care of our own, as that which lies between Portland and Pensacola.

Believing as we do, that the constitution gives the power, we hold that it imposes the duty, of executing without delay the public works to which we have referred; and we trust, that, as soon as an interlude in the angry drama of national politics may arrive, the federal government will admit this to be among the legitimate object for which it was instituted, and seriously resolve upon its execution.

Meanwhile our readers in the great valley, (intelligent and numerous enough of course to exert a commanding influence on its representatives,) will, we trust, bestir themselves on this subject. It is undoubtedly the noblest work of patriotism and humanity, to which the profession of this region can direct their attention; and society has a right to expect from them an efficient exercise on their influence.

We would make a similar call on the editors of public journals in the west and south—indeed throughout the Union; for their assistance would be still more effective, than that of the medical profession. Those who publish in the Valley, will of course "lend a hand," and those who reside east of the mountains, could scarcely fail to co-operate, if they were duly to consider the matter; or even to take of it the limited and selfish view which would connect it merely with the interest of the people of the old states. The view to which we refer is this. A very great number of those who are engaged in the navigation and commerce of the Mississippi and its tributaries, are immigrants from the east, who have left friends, more favored by fortune, behind them, who ought not, who could not if they would, be indifferent to the perils and sufferings of their sons and brothers, that have sought to earn a subsistence in the land of promise—but which to many is a land of hard labor and exposure. Still further, the number of travellers, male and female, from the Atlantic states, that made voyages of business, observation, or pleasure upon our "western waters," is far greater than is generally known; and every year, many of them perish from casualties and disease, who might be preserved, if well conducted infirmaries were scattered throughout the great region, which they attempt to traverse.—Dr. Daniel Drake.

Recent Chicago Meeting One of the Best in History of the A.M.A.; Ohioans Take Prominent Part in Session

THE 7,000 physicians, 400 of them Ohioans, who attended the 94th Annual Session of the American Medical Association at Chicago, June 11-16, had an opportunity to improve their medical knowledge by one of the finest scientific programs in the Association's long history. General scientific and section meetings, scientific exhibits, special exhibits and demonstrations, and the technical exhibits were all of an unusually high caliber. Medical officers from the armed forces participated in many of the programs and furnished some of the most interesting exhibits.

Ohio was represented in the House of Delegates by Dr. Barney J. Hein, Toledo; Dr. Wm. M. Skipp, Youngstown; Dr. George A. Woodhouse, Pleasant Hill; Dr. Harry V. Paryzek, Cleveland; Dr. Edward J. McCormick, Toledo; Dr. Carl R. Steinke, Akron; Dr. C. C. Sherburne and Dr. H. M. Platter, Columbus. Two important reference committee appointments were assigned to Ohio: Dr. Paryzek, Committee on Amendments to the Constitution and By-Laws, and Dr. Steinke, Committee on Reports of Officers.

A resumé of the actions of the House of Delegates will appear in the August issue of The Journal.

A number of Ohio physicians appeared on the scientific programs. (Their names were published on pages 578-580 of the June issue of *The Journal.)* An exhibit on "Industrial Diseases in the Beryllium Industry", by Drs. H. S. Van Ordstrand and Robert Hughes, Cleveland; Dr. J. M. DeNardi, Lorain, and Dr. Morris G. Carmody, Painesville, received a Certificate of Merit in Group 1 of the Scientific Exhibit. Awards are made in this group for exhibits of individual investigation, which are judged on the basis of originality and excellence of presentation.

NEW OFFICERS AND COUNCIL MEMBERS

The new President-Elect of the American Medical Association is Dr. Roger I. Lee, Boston, who has just completed 10 years on the Board of Trustees. A former president of the American College of Physicians and the Massachusetts Medical Society, Dr. Lee has been on the staff of Harvard Medical School since 1907, and has been in private practice since 1924. He is a member of the Public Health Council of Massachusetts, the Committee on Medicine of the National Research Council, the National Advisory Health Council, the American Association for the Advancement of Science, the Association of American Physicians and many other prominent scientific societies. In World War I Dr. Lee served as a lieutenant colonel in the Medical Corps in France with Base Hospital 5 and was consultant in medicine in the Third Corps of the A.E.F. He will succeed to the presidency of the Association in 1945 when Dr. Herman L. Kretschmer, Chicago, completes his term as president.

Other officers elected by the House of Delegates included: Dr. Stanley J. Seeger, Texarkana, Texas, Vice President; Dr. Olin West, Chicago, Secretary; Dr. J. J. Moore, Chicago, Treasurer; Dr. H. H. Shoulders, Nashville, Tenn., Speaker; and Dr. R. W. Fouts, Omaha, Vice Speaker. Dr. Louis H. Bauer, Hempstead, N. Y., was elected to the Board of Trustees to succeed Dr. Lee, and Dr. Elmer L. Henderson, Louisville, Ky., was re-elected to the Board for a second five-year term.

DR. McCORMICK RE-ELECTED

Re-elected to membership on councils were the following: Judicial Council, Dr. Edward R. Cuniffe, New York (1949); and Council on Medical Education and Hospitals, Dr. Charles Gordon Heyd, New York, (1951). Dr. Charles H. Phifer, Chicago, was elected to the Council on Scientific Assembly, for a term expiring in 1949, succeeding Dr. J. Gurney Taylor, Milwaukee.

Dr. Edward J. McCormick, Toledo, was reelected to the Council on Medical Service and Public Relations, which was created at the 1943 session of the House of Delegates. He will serve until 1946. Other elected members of the Council are: Dr. A. W. Adson, Rochester, Minn., and Dr. W. S. Leathers, Nashville, Tenn., (1945); Dr. Thomas A. McGoldrick, Brooklyn, (1946); and Dr. John H. Fitzgibbons, Portland, Ore., and Dr. James R. McVay, Kansas City, Mo., (1947). Other members of The Council are: the President, Dr. Kretschmer; the Past-President, Dr. James E. Paullin, Atlanta, Ga.; the Secretary, Dr. West, and a member of the Board of Trustees, to be appointed by the Board.

DISTINGUISHED SERVICE AWARD

Dr. George Dock, internist and pathologist of Los Angeles, was awarded the Distinguished Service Medal by the House of Delegates on the second ballot. The three nominees presented by the Board of Trustees were Dr. Isaac A. Abt, Chicago; Dr. Simon Flexner, New York, and Dr. Dock. Noted for his work on the pathology of malaria and dysentery, protozoan disease of the blood, pernicious anemia, the ductless glands and hookworm, Dr. Dock is honorary professor of medicine at the University of Southern California School of Medicine, Los Angeles. He was

vice president of the international medical congress at Moscow in 1897 and at London in 1913, and was president of the Association of American Physicians in 1916-17. Dr. Dock was professor of medicine at Washington University School of Medicine, St. Louis, 1910-1922, and was previously on the teaching staffs at the University of Michigan Medical School, Texas Medical College and the University of Pennsylvania.

Among the distinguished guests who attended the meeting were: Major General Norman T. Kirk, Surgeon General of the Army; Vice Admiral Ross T. McIntire, Surgeon-General of the Navy; Surgeon-General Thomas Parran of the U. S. Public Health Service; Air Surgeon David N. W. Grant, and Lieut. Robert Kho-Sheng Lim of the Chinese Army.

Future meetings of the Association are scheduled to be held in New York in 1945; San Francisco, 1946, and Atlantic City, 1947.

School-Community Health Education Project for Ohio Planned

The Ohio Department of Education, in cooperation with the Ohio Department of Health, is making plans for conducting a School and Community Health Education Project in Ohio, beginning with the Fall term, September, 1944. This project has been made possible through a grant received from the W. K. Kellogg Foundation of Battle Creek, Michigan. Funds allotted to the State Department of Education are to be specifically expended for workshops, in-service training of teachers, health conferences, publications, outline of the course of study, and the employment of a full-time health education consultant to supervise the project on a state level.

The purposes of the project are:

1. To prepare senior students in high school for:
   a. Service in the armed forces by providing a pre-induction course in health.
   b. Service on the home front by offering opportunity for specialized training in needed areas as home nursing and first-aid.
2. To improve the health habits of the individual, the family, and the community through utilizing all existing resources of the school and community health agencies.
3. To develop breadth of vision and an awareness among students regarding their community health agencies and the contributions they make to the total health program.
4. To organize a program of health education in the school on the local level to meet the present emergency, and so planned that with slight modification it can be converted into a longtime program in the postwar period.

Various state agencies and organizations are being invited to cooperate and participate in the project.

Main units to be included in the project are: helping students meet general health objectives; helping students meet health objectives for special wartime services; family health; health agencies; community health; the function of the school health program; administration of the health education program.

A number of schools will be chosen on a statewide basis from the city, county, and exempted village classification. Selection will be based upon the following:

1. The need for health education in the school and community, as evidenced by the inadequacy or lack of any organized program of health instruction or health services.
2. The willingness of the school administrator to definitely assign someone to be personally responsible for the health project in the school and community.

A two-week training conference is being planned from August 14th through August 25th at Columbus, for individuals directly responsible for the project. Detailed information will be sent to those schools definitely interested in establishing a coordinated program of health education in the school and community.

Miss Wilma Snider has been appointed assistant supervisor for the project. For the past two years Miss Snider has held the position of instructor of health and physical education at University School, Ohio State University. Prior to this appointment she had several years of experience in the area of health and physical education in the secondary schools.

Appointed to Silicosis Board

The State Industrial Commission has appointed Dr. Ralph W. Holmes, Chillicothe, a member of the Silicosis Board of Referees, succeeding the late Dr. Wm. M. Doughty, Cincinnati. Other members of the Board are Dr. Raymond C. McKay, Cleveland, and Dr. Joseph A. Muenzer, Toledo.

A graduate of the Ohio Medical University, Columbus, in 1901, Dr. Holmes is secretary of the Ross County Academy of Medicine; a member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Radiology, and a member of the American Roentgen Ray Society and the Radiological Society of North America.

Cleveland Selected

The Sixty-Ninth Annual Meeting of the American Association on Mental Deficiency will be held in Cleveland in May, 1945. The exact dates have not been selected. This is the first time the association has met in Cleveland since 1920.

Colonel Jones Retiring as Head of Medical Activities for Fifth Service Command; Successor, Col. E. A. Noyes

AFTER more than 37 years' service in the Army Medical Corps, Colonel E. C. Jones, Fort Hayes, is retiring from an active status on July 1. Colonel Jones has been head of the Medical Department of the Fifth Service Command, Army Service Forces, embracing the states of Ohio, West Virginia, Kentucky and Indiana, for the past four years. Prior to that he had held many other assignments during his long service with the Army Medical Corps. At one time he was an assistant to the Surgeon General of the Army at Washington.



COLONEL JONES

When Colonel Jones leaves Fort Hayes to reside at Unity Farm, "on the banks of Muskingum", Route 77, 20 miles south of Zanesville, he will be succeeded as Surgeon, Fifth Service Command, by Colonel Edgar A. Noyes, Army Medical Corps, now commanding officer of Cushing General Hospital, Framingham, Mass. Colonel Noyes is a graduate of the University of Oregon in 1913 and of the Army Medical School in 1916.

LONG, ACTIVE CAREER

Colonel Jones first retired from the Army in 1938, but two years later he returned to active duty, having volunteered his services for the war emergency. Since that time he has been responsible for the organization of medical facilities and examining teams required in handling the mobilization of inductees in the Fifth Service Command; has aided in the procurement of physicians, dentists and nurses for the Army; and directed the equipping and staffing of the eight general hospitals in the Fifth Service Command and programs to provide adequate medial care for troops in training in this area.

Colonel Jones entered the Army as a contract surgeon one year after graduating from Jefferson Medical College, Philadelphia, in 1906. After graduating from the Army Medical School as a first lieutenant in 1910, he went to Alaska as a post surgeon at Fort Liscum. From 1912 to 1914, Colonel Jones served as a medical officer on the Mexican border and later went with the A.E.F. to France where he was placed in charge of an assembly center at Paris for the organization of surgical hospitals. Later he was given command of a medical department training and supply center at Joinville and after the Armistice he handled the disposition of American medical equipment as a member of a board appointed to settle French claims.

Upon his return to the United States Colonel Jones was assigned to the Office of the Surgeon General at Washington, serving from 1933 to 1938 as chief of the finance and supply division. In addition to his medical training, Colonel Jones also is a graduate of Harvard University Graduate School of Business Administration and the Army War College.

EXPERIENCED MEDICAL ADMINISTRATOR

Successor to Colonel Jones, Colonel Noyes, is a veteran of 29 years of service in the Army Medical Corps. During the First World War, Colonel Noyes first was adjutant of the general hospital at Asheville, N.C., and later was camp surgeon at Camp Custer, Michigan. From 1919 to 1921, he was assistant personnel officer in the Office of the Surgeon General at Washington. After assignments at Sternberg General Hospital in the Philippines; Letterman General Hospital, San Francisco, and Camp Lewis, Washington, Colonel Noyes from 1930 to 1934 served in the professional service division of the Surgeon General's Office. From 1934 to 1937, he was executive officer at the station hospital and the 12th Medical Regiment at Schofield Barracks, Hawaii. He was assigned to Cushing General Hospital last October, after serving six years as executive officer and commanding officer of the station hospital at Fort Banning, Ga.



COLONEL NOYES

The following letter was received recently by the Executive Secretary of the Ohio State Medical Association from Colonel Jones, expressing his appreciation for the assistance which he has received from the Ohio State Medical Association and the medical profession of Ohio generally while in charge of medical activities of the Fifth Service Command, Fort Hayes:

"Mr. Charles S. Nelson,
"1005 Hartman Theater Building,
"Columbus, Ohio.

"My dear Mr. Nelson:

"I am going on the inactive list about July 1st after over 37 years' service in the Army. I came on duty at Headquarters, Fifth Service Command, approximately four years ago. Dur-

Attention: All Medical Officers and Their Relatives! Here Is Method Adopted By Ohio To Provide Those In the Services With November Election Ballot

EVERY Ohio physician serving with the armed forces, at home or abroad, should consider it his duty to vote in the November election.

Under the provisions of a bill passed by the Ohio General Assembly in special session April 27, absentee voting by persons in the service is greatly facilitated. The procedure is simple.

A physician, who is a legal resident of Ohio, may make written application for an absentee ballot to his county board of elections, or a relative may make the application.

Under the law, applications may be made by "the spouse, father, mother, grandparent, father-in-law, mother-in-law, brother or sister of the whole blood or half blood, son, daughter, adopting parent, adopted child, step-parent, step-child, uncle, aunt, nephew or niece" of the voter.

The application need not be in any particular form. It should merely request an absentee ballot; state the branch of the service in which the applicant is serving, and specify the location of his legal residence in Ohio so that the clerk of the county board of elections can determine the precinct in which he is located.

Applications for "war ballots" can be made now. The ballots will be ready for mailing by the clerk of each county board of elections to the absentee voter on or after August 9. In order to be counted, such ballots must be received by the board by 12:00 noon on election day, November 7.

The Ohio law provides that the absentee voter in the service will have an opportunity to vote for national, state and local candidates. The Federal absentee voting law recently passed by the Congress permits the voter to write-in his choice only for Federal offices. It is not legal in Ohio, and therefore any votes cast under the Federal law will not be counted in Ohio.

Never has there been an election in this country of such vital importance to physicians, not only as citizens but as doctors. Issues are at stake which will affect the future course of their lives and those of their families. Ohio physicians with the armed forces can and should express their views through the ballot by using this simple method of absentee voting.

Ballots will be sent to applicants via air mail, so there will be ample time for them to be marked and returned by election day, November 7, if requested promptly.

ing that time, many medical problems have arisen that could not have been solved without the help and cooperation of your office and the medical profession of the State.

"Your office, local medical societies, State Health authorities and individuals of the medical profession have been of the utmost assistance to my office in helping to work out problems in connection with induction, officer procurement and local health conditions. Without such assistance the war effort, insofar as the medical activities are concerned, could not have functioned as efficiently as it has. For that reason, I wish to express to you, and through you to the local medical societies, health authorities and individuals of the medical profession, my appreciation of their help in accomplishing what we have, and I trust that same spirit will be extended to my successor.

"I expect to reside in Ohio on the banks of the Muskingum at Unity Farm, Route 77, 20 miles south of Zanesville, 42 miles north of Marietta and will be disappointed if any members of the medical profession pass that place without stopping. The latchstring will be out.

Sincerely yours,

E. C. JONES,
Colonel, Medical Corps,
Surgeon."

Review and Comments on Prepayment Medical Care Plan Proposed by Mayor LaGuardia of New York City

RECENTLY, the newspapers carried New York City dateline stories about Mayor Fiorello H. LaGuardia's plans to establish a voluntary prepayment medical and health service program in the metropolis.

General provisions of LaGuardia's proposal were revealed as follows in the June issue of *Hospitals*, official publication of the American Hospital Association:

"Mayor LaGuardia's project would go considerably beyond any health insurance plan now in operation. It prescribes coverage as follows: (1) General medical practice at home, office or hospital; (2) specialist services for all treatments and consultations; (3) diagnostic, X-ray and laboratory services; (4) all major and minor surgery, (5) prenatal, maternity and postnatal care; (6) complete child care; (7) preventive care including periodic examinations; (8) visiting nurse services; and (9) all hospital services.

THOSE ELIGIBLE

"Eligible would be individuals and family heads who live in or work in New York City and who earn no more than $5,000 a year. The family designation means husband, wife and children under 18.

"Membership is to be open only through groups. The plan is to be administered by a nonprofit corporation which is scheduled to be organized by next July 1. Mayor LaGuardia hopes to have the plan in operation one year later and anticipates that 18 months thereafter 1,500,000 subscribers will have been enrolled.

"To finance operations, it is expected that 4 per cent of the employee's wage will be required, at least half of this to be paid by the employer.

FREE CHOICE POLICY

"All qualified physicians will be invited to participate and it is hoped that an open panel operation will be possible. If physicians do not respond, however, the plan's sponsors are prepared to set up closed panels, paying salaries from $6,000 to $20,000. In this case, each zone of 100,000 persons would have available one unit of medical skill, made up of 70 general practitioners, seven maternity specialists, 15 children's specialists, 10 surgeons, eight ear, nose and throat specialists and miscellaneous medical men.

"This plan resulted from the deliberation of a committee appointed in April, 1943, by the mayor with himself as chairman and David M. Heyman, president of the Institute of Public Health, vice-chairman."

A more detailed description of the LaGuardia proposal—in fact, a critical analysis of it—was made in the June issue of *The Modern Hospital*, by Louis H. Pink, president, Associated Hospital Service of New York, a voluntary prepayment hospital service corporation.

Mr. Pink's observations and opinions of what he believes may be "the most significant experiment yet undertaken in medical prepayment insurance" are as follows:

MR. PINK'S ANALYSIS

"The health plan proposed by Mayor Fiorello H. La Guardia which has aroused such great interest in New York City is, of course, not yet a definite project but rather a suggestion of what the mayor thinks a health plan should be. Some of the details will undoubtedly arouse discussion and controversy throughout the country, particularly among medical men.

"Mayor La Guardia's plan will cover normal as well as catastrophic illness; that is to say, it will include: general practitioner at home, office or hospital; specialist services for all treatments and necessary consultations; diagnostic, X-ray, and laboratory services; major and minor surgery; maternity care—prenatal and postnatal care for mother and child; child care; preventive care; visiting nurse service, and all other hospital services.

"IT CAN SUCCEED"

"Two outstanding features give the plan real possibility of success, i.e., the open panel system with free choice of physician and the mayor's offer to have the city pay half the cost of a complete medical program for city employes.

"There are no accurate actuarial data with regard to the cost of this plan, which includes not only coverage for catastrophic illness but home and office care. Most of the medical prepayment plans cover only surgery and illness requiring hospital care.

"The medical profession is called upon to underwrite the plan just as the hospitals underwrite the Blue Cross plans, and there is no certainty as to what charge must be made to cover the services rendered. An intelligent guess based upon the various experiments throughout this country and Canada is about all that can be given. Such a plan, including hospitalization, would probably cost $40 annually for an individual, or $90 for a family.

DIFFICULTIES CITED

"The difficulty with a plan as broad as the mayor's is not only that there is little actuarial experience on which to determine the proper cost, but the danger of abuse is considerable. Only eternal vigilance by the medical profession can control this. A workable method for control must be evolved. But if voluntary effort is to reach the people and do a real job, preventive and diagnostic service, home and office care and, eventually, nursing and dentistry must be in-

cluded with medical care and hospitalization. The mayor's plan at least presents a worth-while challenge to the medical profession.

"The power behind it is the 150,000 city employes and their families. It will probably cost the city approximately $8,000,000 to pay half the expense for the employes and their dependents. If only 100,000 employes join, they with their dependents will be a nucleus of some 300,000 subscribers. It is hoped that private employers will follow the city's example.

"In the beginning the plan will probably appeal only to the larger employers. It will be much more difficult to get a large membership through employer-interest in New York, where there is little big industry, than in cities, such as Detroit and Cleveland, where a larger portion of the employes work for a few firms.

CONTROVERSIAL FEATURES

"Two controversial features of the plan are income ceiling and control. Mayor La Guardia's plan suggests a ceiling of $5000 per family, which is considerably higher than any suggested by the medical profession. The medical profession fears chiseling by people of means, who would join the plan merely to get complete service, when they could afford to pay prevailing medical rates. But as a practical matter if there is large volume, the ceiling is not as important as it seems.

"When large groups are enrolled, such as all city employes, it would pay the plan to accept them without much regard to income ceilings, excluding only the more highly paid officials. Perhaps a fair compromise can be made on income ceilings; in any event, from a business standpoint the ceiling should vary with the size and the character of the groups enrolled.

"The second controversial point is control. The mayor suggests a lay board to control business, with the medical board having control over all medical matters, patterned after the dual control in voluntary hospitals and universities. Undoubtedly, many physicans will feel that, if they are to co-insure and save the plan from loss as is proposed, they should have a majority on the board of directors.

"No plan can succeed if the doctors are not paid fair fees and actually receive what they are promised. Whether the financial control is in the hands of laymen or medical organizations, there must be reasonable certainty of collecting the fees or the plan will fail from the start.

BLUE CROSS MAY PARTICIPATE

"It is probable that Associated Hospital Service will be expected to provide the hospitalization and, although no definite conclusion has as yet been reached, it may be asked to use its organization as sales agent for the plan. This arrangement has proved of value in Michigan, Massachusetts and several other localities and a similar relationship now exists between Associated Hospital Service and Community Medical Care, Inc.

"Physicians have never had a reputation for successful business operations. They are professional, not business, men. It is possible that other things being to their liking, they will be content with complete control over all medical standards and affairs, leaving to others the business headaches, which will be many.

"One important point that has aroused opposition is a suggestion by the mayor that the 'total charge will be approximately 4 per cent of the employe's wages'. This has been construed to mean that the charge to each subscriber will be based upon his salary, and that a definite percentage of salary will be deducted, no matter whether the subscriber is married or single or how many children he has. This is customary in the case of social security taxes imposed by government but is not practical in selling insurance or any other commodity upon a voluntary basis. It is discriminatory and is probably contrary to the insurance law of the state.

"It is not reasonable to expect that some people will pay a great deal more than others for the same commodity, unless compelled to do it. The mayor's language should not be construed to mean that he is committed to this method of payment. The statement that the total charge will be approximately 4 per cent was meant to indicate the probable cost of complete medical services.

LA GUARDIA'S VIEWS

"In announcing his plan Mr. La Guardia indicated that he strongly favored the Wagner-Murray-Dingell Bill and regarded this plan merely as an expedient until government is ready to assume control. This has scared a great many people and may make it more difficult to obtain the cooperation of the medical associations and others who believe in voluntary effort.

"However, in a community undertaking of this kind there is no logical reason why those who are for and those who are against the Wagner-Murray-Dingell Bill may not participate and try to fulfill a community need. Those opposed can well argue that if the mayor's plan, which is to be effected through a private nonprofit organization, can succeed there is much less need for the government compulsion and control indicated in the Wagner-Murray-Dingell Bill.

"It probably was not stated clearly enough that the mayor's plan is not a city plan as such. It is to be run by a body of citizens through a non-profit organization and the medical end of it is to be controlled by a medical board. The city as such will have no direct control.

"The mayor's plan cannot succeed without the

full cooperation of the medical profession. Out of his suggestion there should come conferences among the mayor's advisers, the medical organizations and the three existing medical plans in the New York area. It is the hope of all interested in a practical and forward-looking plan that unity can be achieved and that there will be but one medical plan in the community. Medical Expense Indemnity and Community Medical Care, the latter affiliated with Associated Hospital Service, have just completed the legal requirements for a merger in order that they may do more effective work. This is a step forward.

"The merged organizations have not yet determined upon the coverage to be offered but it is generally accepted that, if an agreement is not reached with the mayor, a modestly priced service plan will be offered for catastrophic illness and that in the near future broader coverage, providing preventive features and also home and office care, will be made available. The relationship between Associated Hospital Service and Community Medical Care will be continued with the merged corporation, known as United Medical Care.

"If it proves impossible to get the medical profession and the existing medical plans to agree with the mayor on a united effort, it is probable that the medical corporation that the mayor plans to organize will attempt to work out a plan with a limited panel of physicians, on a salary basis. There are undoubtedly some important differences between what the medical profession desires and what the mayor and his advisers want, but a fair compromise that will permit united effort and the pooling of all resources should be sought. This will make possible the most significant experiment yet undertaken in medical prepayment insurance."

Five Physicians Nominated for Ohio and Federal Legislative Bodies

Five members of the Ohio State Medical Association were nominated for Federal and State Legislative offices at the primary elections on May 9.

Dr. Frederick C. Smith, Marion, now representing the Eighth Congressional District at Washington, was re-nominated for that post on the Republican ticket. The Eighth District comprises Crawford, Hancock, Hardin, Marion, Morrow and Wyandot counties.

Nominees for the House of Representatives of the 96th Ohio General Assembly include: Dr. Errett LeFever, Glouster, Athens County; Dr. C. A. Craig, Cambridge, Guernsey County; Dr. H. V. Dutrow, Dayton, Montgomery County, all Republicans; and Dr. D. C. Houser, Urbana, Champaign County, Democrat.

Unopposed for re-election, Dr. LeFever is a veteran legislator, having represented Athens County in the House of Representatives for 14 years. He was state senator from the Ninth-Fourteenth District for eight years. Dr. LeFever was chairman of the House Health Committee during the past two sessions. Dr. Craig, a candidate for re-election from Guernsey County, was a member of the House Health Committee last session.

Dr. Dutrow recently retired from the Medical Corps of the Army of the United States with the rank of Lieut. Col., after 27 months' service in Puerto Rico. He was for many years legislative committeeman for the Montgomery County Medical Society. A past-president of the State Association, Dr. Houser has also been delegate and legislative committeeman for the Champaign County Medical Society. He is a former chairman of the Legislative Committee of the State Association.

Eighth District Meeting Held June 22 at Rocky Glen Sanatorium

A meeting of the Eighth Councilor District of the Ohio State Medical Association was held at the Rocky Glen Sanatorium, McConnelsville, Thursday afternoon, June 22, with approximately 25 physicians present from the nine counties comprising the district. After a business meeting conducted by the officers, Dr. F. C. Huth, president, Dr. M. J. Thomas, secretary, and the councilor, Dr. George F. Swan, all of Cambridge, the following program was presented: "Medical Trends", Dr. C. C. Sherburne, Columbus, Immediate Past-President of the Ohio State Medical Association and a delegate to the American Medical Association; "Voluntary Prepayment Medical Insurance Plans", Dr. Robert E. S. Young, Columbus, member of the Committee on Medical Service Plans of the State Association. Charles S. Nelson, Executive Secretary of the Association, participated in the discussion.

A resolution was adopted creating a committee, with the Councilor as chairman, composed of the delegates from each county in the district to the Ohio State Medical Association. The purpose of the committee is to meet periodically to consider medico-economic questions, and to act as a liaison committee for the district on problems confronting the medical profession. The new district officers are: Dr. James Miller, Corning, president, and Dr. H. F. Minshull, New Lexington, secretary.

Middletown—New staff officers of Middletown Hospital include: Dr. W. H. Roehll, president; Dr. Hyman Helfman, vice-president, and Dr. Mildred Snyder, secretary-treasurer.

Military Roster of Oho State Medical Association Shows 2,812 Ohio Physicians Now in the Services

THE Military Roster of the Ohio State Medical Association totaled 2,812 on June 21 when the July issue of *The Journal* went to press. Of the total, 2,378 Ohio physicians were listed as in the Army, 367 in the Navy, and 67 in other full-time governmental services for the duration. During the past month, the names of 19 Ohio physicians were added to the Military Roster. Some of these physicians have been in service for a considerable time but this information was not reported to the State Association until quite recently. The names of such men are designated with a star (*) in the appended list of names added to the roster during the past month.

NAMES ADDED TO MILITARY ROSTER

Name	City	Rank
Aufderheide, Vincent A.	Dayton	1st Lt., U.S.A.
*Beardsley, R. C.	Akron	Lt., U.S.N.
*Beery, Wm. R.	Columbus	Capt., U.S.A.
*Blazewicz, S. J.	Columbus	1st Lt., U.S.A.
*Burnett, Harry W., Jr.	Dayton	1st Lt., U.S.A.
Byrne, Robert J.	Dayton	1st Lt., U.S.A.
Clouse, Michael P., Jr.	Dayton	Lt. (j.g.), U.S.N.
*Clouse, Paul A.	Springfield	Major, U.S.A.
*Goughnor, Myron W.	Akron	1st Lt., U.S.A.
Grandin, W. R.	Dayton	1st Lt., U.S.A.
Greetham, James S.	Cleveland	1st Lt., U.S.A.
Johnson, Bernard L.	Deshler	Lt. Comdr., U.S.N.
Kerr, L. E.	Oberlin	Surg. (R), USPHS
*Ley, Gordon R.	Columbus	Capt., U.S.A.
Maimon, Samuel N.	Dayton	Lt., U.S.N.
Smith, Howard Wayne	Ashland	1st Lt., U.S.A.
*Sovik, Wm. E.	Youngstown	Lt. (j.g.), U.S.N.
*Stahl, R. H.	Akron	1st Lt., U.S.A.
Steinberg, Abraham H.	Toledo	1st Lt., U.S.A.

WIN PROMOTIONS

Name	City	Rank
Adams, Archibald M.	Lima	Capt., U.S.A.
Caton, Russell J.	Bucyrus	Col., U.S.A.
Conway, E. E.	Cambridge	Capt., U.S.A.
Eiser, Joseph	Toledo	Capt., U.S.A.
Guthrie, Morris B.	Columbus	Major, U.S.A.
Hammersley, E. R.	Tuscarawas	Comdr., U.S.N.
Hardesty, H. H.	Cleveland	Capt., U.S.A.
Henrie, Charles C.	Celina	Capt., U.S.A.
Hoffman, Henry L.	Cleveland	Major, U.S.A.
Jacoby, Ben E.	Columbus	Lt., U.S.N.
Kunz, F. C.	Akron	Capt., U.S.A.
Lerner, David L.	Cincinnati	Lt. Col., U.S.A.
Lieberman, Harry G.	Akron	Capt., U.S.A.
Martin, Marion R.	Geneva	Major, U.S.A.
McElroy, Wm. D.	Youngstown	Lt. Col., U.S.A.
Moore, Chas. H.	St. Bernard	Major, U.S.A.
Morgan, Chester A.	Van Wert	Capt., U.S.A.
Overley, H. Glenn	Loveland	Capt., U.S.A.
Parker, Watson D.	Sandusky	Lt., U.S.N.
Pillerdorf, Louis	Cleveland	Major, U.S.A.
Press, Sanford	Steubenville	Capt., U.S.A.
Reese, Harold J.	Youngstown	P.A.S.(R), U.S.P.H.S.
Richards, Robert R.	Lakewood	Capt., U.S.A.
Risley, C. T.	Conneaut	Major, U.S.A.
Stolzer, Irvin H.	Cleveland	Capt., U.S.A.
Stoughton, W. A.	Columbus	Lt. Col., U.S.A.
Ward, Charles F.	Cleveland	Lt. Comdr., U.S.N.
Weaver, Samuel W.	Youngstown	Major, U.S.A.
Wilson, Judson D.	Columbus	Comdr., U.S.N.
Yordy, Paul	Dayton	Comdr., U.S.N.
Zeligs, Meyer A.	Cincinnati	Lt. Comdr., U.S.N.
Zollinger, Wm. K.	Cincinnati	Capt., U.S.A.

TABULATION BY COUNTIES

Adams	2	Guernsey	6	Muskingum	10
Allen	37	Hamilton	432	Noble	1
Ashland	12	Hancock	13	Ottawa	9
Ashtabula	17	Hardin	7	Paulding	2
Athens	11	Harrison	4	Perry	4
Auglaize	6	Henry	3	Pickaway	5
Belmont	14	Highland	8	Pike	2
Brown	4	Hocking	4	Portage	2
Butler	30	Holmes	2	Preble	7
Carroll	1	Huron	15	Putnam	6
Champaign	9	Jackson	1	Richland	38
Clark	32	Jefferson	28	Ross	24
Clermont	9	Knox	11	Sandusky	11
Clinton	8	Lake	18	Scioto	20
Columbiana	11	Lawrence	6	Seneca	12
Coshocton	4	Licking	17	Shelby	7
Crawford	9	Logan	8	Stark	98
Cuyahoga	678	Lorain	39	Summit	150
Darke	6	Lucas	157	Trumbull	27
Defiance	4	Madison	6	Tuscarawas	20
Delaware	7	Mahoning	118	Union	2
Erie	10	Marion	16	Van Wert	9
Fairfield	9	Medina	12	Vinton	2
Fayette	2	Meigs	3	Warren	4
Franklin	229	Mercer	6	Washington	8
Fulton	6	Miami	13	Wayne	14
Gallia	5	Monroe	1	Williams	3
Geauga	4	Montgomery	150	Wood	18
Greene	6	Morgan	3	Wyandot	3
Total					2812

Ohioans are Re-elected by American College of Chest Physicians

Dr. John H. Skavlem, Cincinnati, was re-elected as the Governor of the American College of Chest Physicians, for a term of three years, at the Annual Meeting of the College held in Chicago, June 10-12. Other officers re-elected include: Dr. Louis Mark, Columbus, Regent for District No. 5, comprising the states of Michigan, Ohio, and West Virginia, and member of the Executive Council of the College; Dr. Joseph C. Placak, Cleveland, chairman of the Board of Regents.

Ohio physicians who attended the meeting were: Dr. B. L. Chipley and Major Arthur B. Madden, Chillicothe; Dr. Chas. M. Siegel, Cincinnati; Dr. J. M. Appel, Dr. Milton B. Cohen, Dr. Harold G. Curtis, Dr. Raymond C. McKay and Dr. Placak, Cleveland; Dr. Casper H. Benson, Dr. George M. Curtis, Dr. Myron D. Miller and Dr. Mark, Columbus; Dr. Lynne E. Baker, Dayton; Dr. Edward M. Miskall, East Liverpool; Lieut. Henry Bachman, Delaware; Dr. Lena M. English, Kent; Dr. Ernest Holsted, Lima; Dr. R. G. Plummer, Newark; Dr. A. S. Mack, Oak Harbor; Dr. William J. Forne, Rocky River; Dr. William A. Clark, Springfield; Dr. Edgar C. Baker, Dr. Hubert S. Banninga and Dr. Elmer E. Kirkwood, Youngstown.

Murray Kornfeld is executive secretary of the American College of Chest Physicians, with offices at 500 North Dearborn St., Chicago 10, Ill.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WHAT ARE YOU GOING TO DO ABOUT THE ELECTION ?

Ask the average doctor what he thinks about the forthcoming November General Election and he'll probably say: "Important as Hell, take it from me!" Sure enough, but what's he going to do about it? That's the $64 question. About time for him to be deciding what part he as an individual and his county medical society are going to take in the activities leading up to one of the most vital elections in the country's history.

That other groups are going to play an active role in the pre-election campaign is evident on all sides. For example, take a look at the following excerpts from an article written by Bob Crater and published in the June 18 issue of *The Columbus Citizen:*

"Jack Kroll, president of the Ohio CIO Council and director of the Fifth Regional CIO Political Activity Committee, and George De Nucci, secretary-treasurer of the state council and state director of political activity, are in Washington, D. C., today, attending the much-publicized national CIO political action committee meeting.

"There is political activity in Ohio, heartily sponsored by the state council.

"There is money being spent, the greater part of it to elect Roosevelt to a fourth term.

"The organization created during the past year for CIO political activity is comprehensive and cannot fail to help Roosevelt, should he run.

"The state council sent 22-page leaflets to key men. It listed minute instructions for the organization of political activity groups in Ohio.

"The leaflet's cover page states:

" 'Suggestions for CIO local union, council and county political action committees.'

"In its introduction the intent of political activity is plainly expressed:

" 'The work of the County CIO Political Action Committee is that of co-ordinating and encouraging political action work in the county and supervising this work; also of acting as the county policy-making body and as the committee making all endorsements of candidates for the State Senate and State House of Representatives and for all county offices.'

"The following divisions have been made: (1) Local union political action committees. (2) County political action committees, ward-precinct block files and ward-precinct block organization. (3) County political action program, register-to-vote campaign, educational program, contacting elected and appointed officials, making endorsements, getting out the vote and year-round political action.

"The leaflet leaves little to the imagination. If the plan is followed through by the rank and file, the CIO will turn out its greatest vote percentage in the history of the organization."

Looks as if it is about time for physicians to do a little "block canvassing". Certainly it is high time that every doctor and his family begin to find out about the candidates for public office; what they stand for; what their qualifications may be.

In the near future the Legislative Committee of the Ohio State Medical Association will have some suggestions for local activity by County Medical Societies, woman's auxiliaries, and physicians individually. When the signal for action is given it will behoove each Ohio physician to get busy.

"Efforts on the home front must be integrated with those on the battle fronts. ***When a doctor picks up and moves from a community where he is needed and moves to one where he is not needed, he not only deserts that community, but in addition, disturbs the attempted undertaking of maintaining an equitable distribution of doctors. ***let us recognize the difference between legal rights and moral rights; let us remain at our posts of duty for the duration."—Indiana State Medical Journal.

SOCIAL PLANNERS, SECURITY AND ORGANIC LAWS

We wish that everyone, and especially those who are in a dither about this proposal or that proposal designed to give "security" to all, could be afforded the opportunity to read the text of the address delivered to the last graduating class of the Western Reserve University School of Medicine by Dr. Louis J. Karnosh, professor of psychiatry, and published in the school's official bulletin.

Dr. Karnosh's advice to the graduates, especially his critical analysis of present-day social planning and the social planners, is a masterpiece. Examine the following excerpts from his address and we are sure you will agree:

"And yet, there is inchoate in the contemporary atmosphere a scheme to make the physician and his art a standardized commodity like baked beans and salted peanuts. For the social planners are again upon the land to regulate things, to distribute happiness and to assign six morning glories to every front porch. Again there is inchoate a scheme to make life more happy and secure for the 'common man' and to make it economically nice and comfortable for the mass. We hear them talk grandiloquently of the 'Century of the Common Man'.

"What an incongruity! At the same time that the Utopians are groping for a synthetic universal happiness, there exists the dire necessity for desperate national defense, for mass de-

struction of our enemies, for appalling material waste and wild political disorder. In the din and destruction of bombing, the social engineers are protecting themselves with one hand and with the other they are blithely busy planning a stereotyped happiness and a 'rational' regulation of society.

"What a paradox! There is a drive to regulate the practice of organized, legitimate medicine while hundreds of commercial enterprises are free to sell their headache tablets and carminatives over the radio without stint or economic hindrance. The four freedoms to the dispensers of vitamins, but a sharp regimentation of the physician, of the hospital, and of the cost of legitimate medical care!

"There are certain sound and fundamental reasons for the instinctual distrust of the social planner by the physician—the least of which is his concern over his own economic security. By reason of his knowledge of organic life, the doctor of medicine knows that the social rationalists are anything but rational. The doctor knows that the more significant the culture, and the more natural and sound the social structure, the more it resembles the anatomy of a noble animal or vegetable body and the greater are the differences between its constituent elements.

"More than anybody else, the doctor knows that society rests upon the inequality of men just as the organic body of men functions smoothly with tissues of different duties and different levels of refinement. There is no teleologic absurdity in the question as to what would happen to human efficiency if the connective tissue cell demanded the same protection and choice office as is enjoyed by the upper neuron. What would happen if the red cells went on a strike and demanded the same privileges and duties of a leucocyte? * * *

"That all men are entitled to the same opportunities, no sane person can deny; but that all men can utilize these opportunities to equal advantage defy the law of organic inequality. * * *

"Security against want and sickness, say the social engineers, will make man a happier and more efficient being. As if happiness were a synthetic commodity which could be regimented like canned peaches or predicated like the wheat crop under government restrictive control! 'No', says Dr. Dodds of Princeton, in his new book, 'Out of This Nettle, Danger', 'For society, concentration upon security as a goal is suicidal, doomed to practical as well as spiritual failure. Happiness and security at best is but a by-product recovered in the process of living. When we make the mistake of placing our hope in measures of security rather than in a willingness to venture toward larger growth, decay has begun.'

"As students of human nature, we physicians have a right to pose the question: Does man really want security, does he want the torpid calm that goes with it; does he want such a political soporific? Or does he want excitement attended with an element of risk and does he actually require the exercise of striving, of contending and of endangering life and limb as a necessary instinctual expression of life?

"In a recent play by Thornton Wilder, a character answers this question in these words: 'Every good thing in the world stands on the razoredge of danger.'

"Man races toward security, stops short of its attainment and deliberately deflects his course to endure stress, strain and emotional exercise. For it is the one best manifestation of



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If Your Journal's Late . . .

Please be as patient and tolerant as possible if you do not receive your copy of *The Ohio State Medical Journal* as promptly as in the past. Shortage of labor in our print shop and the preference which Uncle Sam must give to first-class mail have combined to make it virtually impossible for us to get *The Journal* to all readers as early each month as desirable. Wait until the 15th day of the month before assuming your copy has gone astray. If you don't get it by that time, let us know and we will endeavor to supply a duplicate.—*The Editor.*

life that hazards be thrust upon him, and only by accepting this destiny, can man know freedom. It resolves itself into the axiom that man cannot have security and freedom at the same time. That he inherently values freedom more than he does security is attested to by the historical fact that he will quickly abandon the latter for the former—rarely the reverse.

"Social planners naturally disagree on how to become secure, because at a given moment the word 'security' does not mean the same thing to two people even though they find themselves in the same economic situation. Some call social security 'merely a slice of today's surplus for tomorrow's deficit'. Security certainly offers no freedom from fear and particularly fear of pain, of disease and of the unpredictable and the unknown.

"With all the logical foresight which can be mustered, with all the beautiful paper plans to put medicine on the assembly line, the human emotional experiences of pain, fear of disease and all the sorrows epitomized in 'Ol' Man River' will continue to torment man and to defy regimentation and bureaucratic control.

"Even the best of rational social planners, when he is personally beset by that most irrational and nonregimentable thing called fear, cannot fail to realize that the practice of medicine is no stereotyped and standardized commodity. If he finds himself fearful that he has a brain tumor, will he be enrolling to go to his panelized central clinic for routine treatment? No, I think not; you will more likely spot him in a few days within earshot of the carillons pealing their chimes from the top of the Plummer Building in the medical shrine at Rochester, Minnesota, or sitting in the waiting room of the sages of intracranial physiology at Baltimore. If, in his morbid apprehension, the chimes at Rochester happen by coincidence to be playing the evening anthem, 'Nearer, My God, to Thee', his pains will irrationally increase. He soon finds that his unregimentable emotions are more ultimately wise in directing him than are his rational and sociological notions. Unerringly, he shall recognize there are and always shall be good, bad and indifferent types of medical services, that there are grades of A, B, C, and D, as there are good, bad, and indifferent apples in his orchard. He shall be smitten by the omnipresent, emotional, organic element in medical practice. And he will then discover that the emotions of men cannot be socialized and regulated by bureaucratic edict.

"The sociologist will harass medicine. Of this there is no doubt, and it is your divine duty to protect it from such inane manipulation. The social idealist will gnaw at its periphery, as he is already doing. He will regiment everything he can, but because the soul of medicine rests on an organic evolution, he will ultimately fail. Only when a painting by Rembrandt will bring the same price as a finger daub done by a Greenwich Village neurotic, only when pain, fear and mortal ills can be levelled to a standard scale, will medicine become an article of commerce and you will become spiritless automatons and dispensers of pills and surgical incisions."

WHAT WILL YOU DO TO HELP RETURNING PHYSICIANS?

Just about every organization worthy of a title is making postwar plans. In fact, there has been so much talk about postwar planning that the subject has become a bit shopworn. Nevertheless, now is the time for serious thinking and planning about means of handling problems which will arise as the war nears its close and actually ends.

So far as the medical profession is concerned, there are many vital questions which fall into the general classification of postwar problems. Some of them, such as providing facilities for postgraduate and refresher course education for returning medical officers, bringing about a better distribution of medical and health facilities, relocation of physicians, etc., are questions which will require organized effort on the part of national, state and local medical societies, in cooperation with other groups and agencies. The Ohio State Medical Association has committees at work on some of these extensive questions.

On the other hand, there will be a multiplicity of little problems which will confront returning medical officers, many of them highly personal in nature. The answers can be provided for many such problems by individual physicians on the home front if they will be willing to take a personal interest in helping the returning officer get readjusted to civilian life.

In our opinion, two things should be done immediately:

1. Each County Medical Society should have a committee (new or existing com-



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HERE is a Report to the Nation on the wide-spread activities of America's doctors in a world at war, not only on the battlefronts, but on the home front as well. Documentary histories of medical heroism, carefully authenticated and ethically presented, should prove of interest to every physician, military or civilian. The comments or suggestions of the profession are welcomed.

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mittee) at work on a program of things which the local society can do to help each medical officer returning to the county become easily and rapidly readjusted to civilian life.

2. Each physician should ask himself: "What can I do personally to help my colleagues when they return to civilian life?"

The up-and-coming Medical Society of the District of Columbia has done an excellent piece of work along these lines. It has a special committee. Recently that committee polled the members of the society to ascertain the cooperation which might be expected from physicians remaining at home in helping to meet the problems of the returning medical officer. The answers obtained are enlightening and offer clues to all local medical societies and individual physicians as to what should and can be done.

Twenty-five doctors stated they would be willing to share office space with a returning physician; 14 reported they were holding office space pending the return of associates; 10 expressed a willingness to stagger office hours, making it possible for another physician to use their offices, and 3 said they would be willing to share office space until the income of the returning doctor is established.

The District of Columbia physicians who participated in the poll offered some valuable suggestions and comments. Among them were the following:

"Will refer all calls after 11:00 p.m. to men in general practice returning from the service."

"Will refer as much work to them as possible in otolaryngology, pediatrics, obstetrics."

"Encourage group practice where feasible."

"Establish a sinking fund with $5.00 monthly [contribution] from members as a loan source . . . repayable to contributors [or an] outright gift to the fund."

"Return . . . former patients . . . [where] possible."

"Sponsor hospital refresher courses."

"Form a committee whose only function is to aid returned men from the service."

"Go on record approving reinstatement of all doctors to previous hospital appointments without loss of seniority. . . ."

"Would advise that the society write all physicians in the armed forces and prepare a roster of those desiring assistance in getting reestablished. . . ."

"Every physician should be able to take a vacation for at least two months and let a returning physician take over his practice and in that way get a start. I personally would sign such an agreement."

"The committee might inform itself concerning current leases and the date of expiration . . . so that proper contacts may be made at the earliest opportune moment. . . . Many returning physicians will, in this way, be afforded office space upon their return to private practice."

"I have a guest room available in my home. I would consider it an honor to extend the courtesy [the use of the room] to a colleague until he could make permanent arrangements for himself and his family."

Here you have a few definite ideas about postwar planning—ideas which could be translated into action by any medical society and any individual physician.

It is hoped that all County Medical Societies in Ohio will not neglect their responsibilities in this field. If the society feels that no organized program is needed, it at least can undertake the job of inspiring its members to get ready now to offer those little personal services and kindnesses which will mean so much to all returning medical officers.

MOVE TO KILL SALES TAX SHOULD BE SCUTTLED

Petitions are being circulated by a group of Clevelanders to place on the ballot at the November election a proposed constitutional amendment which would repeal the present Ohio Retail Sales Tax and prevent the state from raising revenue in the future through that form of taxation.

Physicians as a large and substantial group of taxpayers should be more than casually interested in such projects. In this particular case, it is our opinion that all Ohio physicians should take an active part in discouraging the signing of such petitions.

Naturally, the sales tax is not perfect. What tax law is? Nevertheless it is the best revenue-producing law on the books today and probably the most painless. It produces most of the revenue required by the schools and for financing of old age pensions. Part of it is returned to help in the financing of operations of local city and county governments.

If the sales tax is to be shelved, what method of taxation will be used to secure the millions of dollars which the sales tax is now producing and which are needed by the state and local governments and schools? An income tax? A gross receipts tax? The sales tax spreads the responsibility for helping to support government among all citizens while the income tax would crack down hard on a comparatively few. In states which have adopted the gross receipts tax, the small business man has been forced to shoulder a tremendous burden as he has found it virtually impossible to pass on the tax to the consumer.

Don't be fooled by the references being made to the "huge state surplus". Yes, the state has a surplus but it is there for the proverbial rainy day which is bound to come. It wouldn't last long if used for current operating expenses in lieu of funds which would be lost through repeal of the sales tax. It is there for meeting deficits and for special postwar projects, such



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Remember the days when people scoffed at the "dreams" of a few men... dreams of the average American "taking to the air"? Year by year, increasing numbers of travelers... no longer chained to earth by fear and ignorance... whisk through the air and accept it as a regular part of life.

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as a welfare institution building program, not for meeting current expenses.

The move to kill the sales tax should be stopped before it gets a good start. With all its weaknesses, the sales tax is the most equitable and substantial revenue-raiser of all forms of taxation, its critics to the contrary not withstanding.

It would be well for physicians to point out these facts to their friends and patients, discouraging them from giving any support to the repeal project until someone comes along with a method which will produce as much revenue and in as painless a manner.

Commenting on the argument regarding the Wagner Bill in the Washington, D.C. Sunday Star, Edward A. Harris said: "So broad scaled is the attack that the administration may take the issue to the people in the forthcoming presidential campaign." Which will be o.k. by us, Mr. Harris.

OUR PROGRAM CRITICIZED AS TOO SAFE

Several months ago *The Medical Woman's Journal* editorialized against the Wagner Bill. Mention was made of the folder produced by the Ohio State Medical Association pointing out the dangers of that proposal.

In the May issue of *The Medical Woman's Journal*, Dr. Rachelle S. Yarros, La Jolla, Calif., a member of the editorial board of that journal, who labels herself "an independent New Dealer as well as a member of the insurgent group", takes issue with the statements made in the editorial.

Dr. Yarros admits she is a follower of Hugh Cabot, John P. Peters and others of the group of "progressive, socially-minded doctors and eminent professors of medicine". She contends that "this public-spirited group" is not open to the charge of seeking to regiment the people or enslaving and exploiting the doctors. Her view is that this group "is actuated solely and simply by the desire to reduce excessive medical costs, modernize the business side of medicine, and improve medical education with a view to better prevention of sickness and better protection of public health". Dr. Yarros alleges that the program of the Ohio State Medical Association "is no serious alternative to the Wagner Bill . . . dodges the main issue . . . indulges in safe and glittering generalities".

Maybe so! Nevertheless, without taking Dr. Yarros too seriously, we would like to raise the following questions:

Who is naive enough to think that the program of Cabot, Peters, et al, is void of regimentation of both the people and the doctors?

Who ever heard of a government bureau winning medals for reducing the costs of anything?

Since when did government become a model for efficiency of business details?

How would medical education be improved by government supervision and meddling?

Is the Ohio State Medical Association's program worthless simply because Dr. Yarros doesn't like it?

Who ever heard of "an independent New Dealer"?

As a concluding shot, Dr. Yarros pleads: "Let us women earnestly study important political and social questions, seek information in the right quarters, and soberly reach our own conclusions". We suppose she means "seek information" from Cabot, Peters, Wagner, Murray and Dingell who are not the "right quarters" in our book.

TALLMAN APPOINTMENT A GOOD OMEN

In the June issue, *The Journal* carried a news article relative to the selection of Dr. Frank F. Tallman as Commissioner of Mental Diseases for the State of Ohio. In our opinion there are a number of significant angles to the selection of Dr. Tallman for this important post.

First: Dr. Tallman's record indicates that he is especially well-qualified as a psychiatrist and

---

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Since cosmetics are so universally used it is not to be wondered that they sometimes figure in the field of allergy. We venture the opinion, however, that cosmetics figure less frequently in this field than many common foodstuffs, and certainly no more frequently than many articles of clothing. Many a contact dermatitis that might formerly have been ascribed to cosmetics is now traced to dog dander, house dust, elm sap, bed linen, etc.

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has had the administrative experience which the position requires.

Second: Those who are familiar with Dr. Tallman's work in Michigan and in New York and know him personally, state that he is no theorist and dreamer but a practical administrator with a solid technical background.

Third: Selection of a man of this caliber to head up mental hygiene activities in Ohio indicates that at long last Ohio is going to make a sincere effort to bring its program for the care of the insane and mental defectives into line with progressive states.

Fourth: To get Dr. Tallman, or a man with similar qualifications, Ohio learned that it had to open its purse strings. The fact that Ohio was able to obtain the services of Dr. Tallman by raising its customary salary level for administrative positions would seem to prove that the state has been following a shortsighted policy in failing to recognize that qualified talent for highly specialized positions can not be acquired under sub-standard salary schedules.

When Dr. Tallman takes over his duties in Ohio, he will, we are confident, have the full cooperation of the medical profession of the state and its state and local societies. An enormous job confronts him. He will need plenty of assistance, especially from groups which are as sincerely interested as the medical profession in improving Ohio's mental hygiene program. We don't expect Dr. Tallman to perform miracles. Nevertheless, under the leadership which he is capable of giving to the division, real progress may be anticipated.

WILL CONFIDENCE OF PUBLIC BE MAINTAINED?

According to a poll taken by *Fortune Magazine*, the public indicated that it looks to its business leaders to take most of the initiative in getting the economy to run smoothly after the war. Commenting on the survey, *Fortune* makes these significant observations:

"Business today enjoys the confidence of the U. S. public probably to a greater degree than at any time in recent years. But as business leaders well know, the task involves more possibilities for losing the public's confidence than almost any task that could be assigned."

Recent surveys made by other agencies indicate that the medical profession also enjoys the confidence of an overwhelming majority of the public. At the same time, we are of the opinion that responsibilities similar to those resting on the shoulders of business leaders also must be faced by leaders in the medical profession.

The public expects the medical profession to bring about improvements in methods of distributing and spreading the benefits of curative and preventive medicine. The confidence which the public has in the medical profession can not be maintained to such a large degree unless the profession makes vigorous efforts to meet these responsibilities and displays more leadership in efforts toward readjustment than has been shown in some areas to date.

The challenge is on the doorstep of each medical society. True, the individual physician has a certain role to play but, in the final analysis, the approach must be through organized efforts. It is high time for each County Medical Society to appraise the situation in its own bailiwick and ask itself these questions: "Are we meeting local responsibilities? What are the medical and health problems in our county awaiting to be solved? What can we do as an organization to try to solve them?"

There is plenty of evidence to indicate that other organizations and agencies are itching to take over activities which should be led and supervised by the medical profession. They will do so, mark you, unless the medical profession beats them to the draw.

According to Hospitals, official publication of the American Hospital Association: "Congressmen in Washington have said recently that the tone of the mail they are receiving these days indicates to them that a new campaign, designated to urge early consideration of the Wagner-Murray-Dingell Bill is under way." Better keep your ammunition dry, doctor.

FARM BUREAU FAVORS VOLUNTARY MEDICAL, HOSPITAL PLANS

The following resolution was adopted at the recent annual convention of the American Farm Bureau Federation and women's auxiliary held in Chicago:

"We favor an intensive attack on the problems of better medical and hospital care for all groups. This is particularly necessary in rural areas. In general, we favor action on this problem by the voluntary organization of cooperative health and hospital associations. We stand ready to cooperate with the medical profession and other groups in the solution of this problem."

With the general principles expressed, we agree, and we commend those groups for their stand for free enterprise and voluntary action. However, in facing the problem of better medical and hospital care for rural people, farm organizations should not fail to realize that the real solution lies in improvement of the economic and social conditions of rural areas. Medical and hospital services are only a small part of the program.

What is meant by "cooperative health and hospital associations" we do not know. Some which have been organized or proposed have contained

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provisions detrimental to health by causing a lowering of the standards of medical care.

The offer of the Farm Bureau to cooperate should be regarded as a challenge by the medical profession. Improvements can be brought about if farm groups and the medical profession will work together, keeping in mind at all times that the only program which will be of ultimate value is that which will provide recipients with good, not necessarily cheap, medical and hospital care.

SALE OF UNPRESCRIBED VITAMINS TOO LARGE

According to the latest issue of the quarterly publication of the New York Trust Company, the volume of production and sales of the drug industry has increased 55 per cent since the start of the war and "every third customer in a drug store now purchases a vitamin preparation of some kind with such products selling at the rate of more than $200,000,000 a year".

We are pleased, naturally, that our friends in the pharmaceutical field are prospering. Nevertheless, the report with respect to the sale of vitamin preparations must be viewed with some concern. Too many persons are purchasing vitamins on their own initiative and before obtaining the advice of their physician. Such practices are not only extravagant but just as injurious as all other practices which involve self-diagnosis and self-prescribing.

Plenty of additional education needs to be done to keep the use of vitamins within bounds. Physicians in their practices should make it a point to advise their patients when vitamins are needed and to avoid them when they are not indicated. Much of the value of vitamins as a supplement to a balanced diet in specific cases will be counteracted unless a more rational attitude is taken by the public at large.

LET THE NEW YORK SCANDAL SERVE AS A WARNING

Following are excerpts from a story published in the June 4 edition of *The New York Times:*

"In a collective action unprecedented in the annals of New York State Workmen's Compensation Law, Industrial Commissioner Edward Corsi of the State Labor Department dealt a blow yesterday at a widespread 'kickback' racket by revoking the licenses of nine Brooklyn physicians to treat compensation cases and suspending 263 others for periods ranging from one month to two years.

"He said the disciplinary action was based on recommendations of the Compensation Board of the Medical Society of Kings County. This board heard charges against more than 1,000 Brooklyn doctors accused of accepting 'kickbacks' ranging from $1 to as high as $1,127 over a single period of twelve months.

"Similar penalties against physicians in Manhattan, the Bronx, Queens and Westchester County will be announced this week, Commissioner Corsi said.

"A clean bill of health was given to ten Brooklyn physicians on the recommendation of the medical society, and it was found in seventy other cases there was no cause for action, Commissioner Corsi said. He added that further hearings are to be held in the cases of 302 other Brooklyn doctors, while charges against 343 physicians now in the armed services will be 'filed' for the time being.

"These 'kickbacks', the report said, appeared to have been paid to doctors by surgeons, roentgenologists, surgical appliance houses, opticians and specimen analysis laboratories to whom they referred workers.

" 'It is far from a pleasant duty to take this action against such a large group of professional people, especially when we considered that many of them, through long years of study and faithful application, have earned positions of respect and confidence in their communities', Commissioner Corsi said.

" 'But this is an instance wherein the protection of the public welfare far transcends personal preference; one that men privileged to be part of such a noble profession as medicine should never have permitted to exist.' "

This sordid story does not make pleasant reading for the medical profession at large. Certainly, *The Journal* derives no pleasure from publishing the above excerpts from an article which already has been read by thousands of people who like to feel that their doctor and the medical profession as a group are entitled to reverence and respect.

The reason we have seen fit to comment on the New York situation is that we see in it an opportunity to voice a warning that the medical profession can not endure publicity which slashes at the honor, dignity and honesty of the entire medical profession. The basis for that kind of public relations must be eliminated.

Public confidence in the integrity of the medical profession can just as easily be shaken in Ohio as in New York. Some of the files of the Ohio Industrial Commission provide evidence that Greater New York City has no exclusive claim on "kickbacks" and other forms of dishonest and unprofessional practices on the part of some physicians handling workmen's compensation cases.

The overwhelming majority of the doctors in Ohio, in our opinion, are doing an honest job in their relationships with the Industrial Commission. But, as in New York, there are a comparatively few who are engaging in shady practices and abusing their privileges. Unfortunately, the entire profession is blamed for the corrupt practices of a few.

Those doctors who are cutting the corners in their dealings with the Ohio Industrial Commission would do well to think twice about what has occurred in New York. It can't happen here? Oh yes it can—and will, unless offenders heed the warning which is found in the courageous action taken by the honest doctors and by the workmen's compensation officials of the State





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of New York. The honest doctors in Ohio are just as anxious to protect the reputation of the medical profession and just as willing to cooperate in breaking up racketeering as those of New York. If drastic action should become necessary, it is our opinion that the medical profession of Ohio will do its part for in the end its stake in seeing that similar conditions shall not be tolerated here is a big one.

SILENT MAJORITY, VOCAL MINORITY !

Edward L. Bernays, "U.S. publicist No. 1", writing in the March issue of *The American Mercury* after a survey of public opinion concludes: "All of which enables me to predict, for the next six months, a truly united country despite surface manifestations of disunion that make headlines. Crackpots, agitators and panicky individuals speak only for a small and negligible minority of the emerging American public opinion. The silent deep-running opinion of the preponderant majority will present an almost unanimous devotion to winning the war and supporting democratic ways in politics and economics." Support with votes would be a big help, in our opinion. Too much silence is not recommended.

CHANCE FOR OHIO TO PROVE IT CAN RUN ITS OWN AFFAIRS

In the June issue of *The Journal*, pages 567-568, there appeared an article pertaining to plans which had been developed to provide medical and health services for farm laborers recruited within Ohio, or transported into Ohio, to work on Ohio farms.

Since arrangements were worked out between representatives of the Ohio State Mdical Association, the Agricultural Extension Service, Ohio State University, and the Office of Labor, War Food Administration, Chicago, there has been one new development of significance.

Originally, it was planned that medical and health services for farm laborers imported into Ohio and who are not Ohio residents would be supervised by the Midwestern Agricultural Workers Health Association and the Health Services Division of the Chicago Office of Labor, War Food Administration. Under the modified program, the latter organizations will assume no responsibility for the operation of the medical and health program for farm workers in Ohio. Complete supervision will be handled by the Agricultural Extension Service, Ohio State University, with which the representatives of the State Association had negotiated in the beginning.

In other words, the responsibility for seeing that transient farm laborers in Ohio are supplied with proper medical care and health services will rest entirely in the hands of Ohioans—officials of the Agricultural Extension Service and the physicians and health commissioners of Ohio.

Although the Federal Government will provide the money for the operation of this important program, administration and supervision will be in the hands of Ohio officials. This is in line with principles which have been endorsed on numerous occasions by the State Medical Association, namely, that if it becomes necessary to use Federal funds for essential activities, administrative details should be delegated to responsible state officials, agencies and organizations.

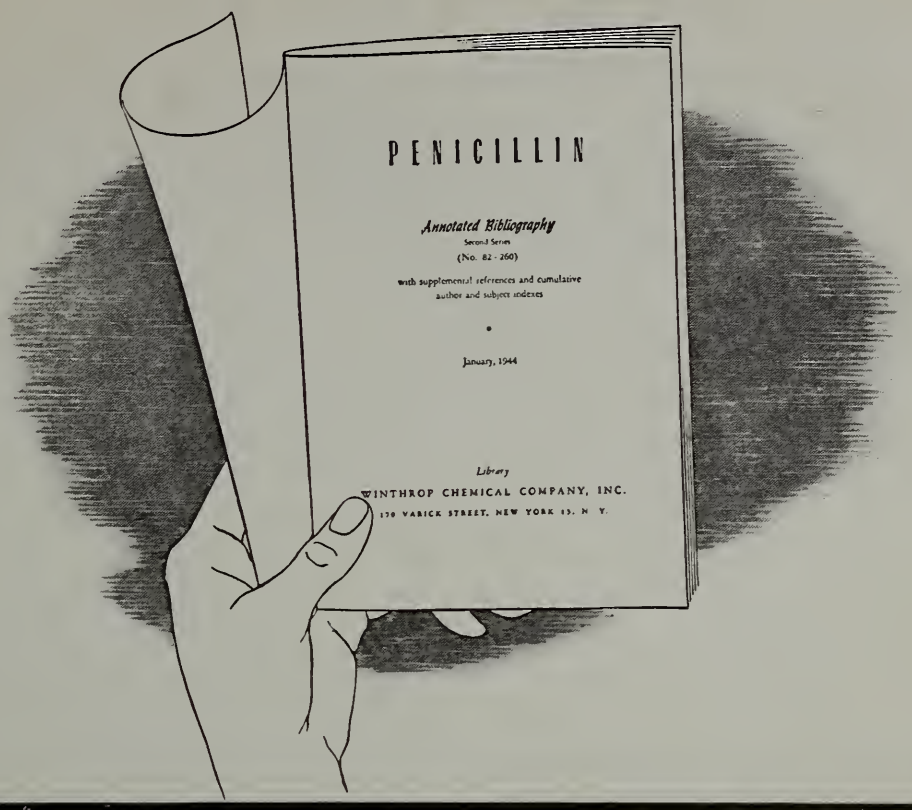
In our opinion a better job can, and will, be done under the new setup which calls for local responsibility and precludes interference by agencies outside Ohio.

It is up to the physicians of Ohio to produce and to cooperate in making the program work efficiently. Representatives of the Agricultural Extension Service—the county farm agents—will have the job of local supervision. They are seeking the assistance of County Medical Societies. They should be given wholehearted support. The presidents and secretaries of County Medical Societies have been supplied with recommendations by The Council of the Ohio State Medical Association—recommendations which can be adapted to meet local situations and needs by each County Medical Society.

Here is a chance for the medical profession of Ohio to show what it can do and to prove that Ohio doctors, working with responsible Ohio agencies, are capable of providing adequate medical and health services for all who reside in Ohio—whether temporarily or permanently. If this all-Ohio program flops, the reaction will be bad and intervention by Federal officials trying to meet the farm labor problem will be inevitable. The program will not fail if physicians individually and collectively will do the job in a realistic and cooperative manner.

Blakiston Assets Sold

Doubleday, Doran & Company, Inc., has acquired, through a wholly-owned subsidiary company, the assets and business of The Blakiston Company, Philadelphia, as a going concern. Under the name of The Blakiston Company, this firm will continue its present business of publishing medical and scientific books and the performance of existing contracts. The Blakiston Company will also engage in a general publishing business under its own name and imprint. The offices will continue at 1012 Walnut Street, Philadelphia 5, Pennsylvania.



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WAR NOTES

To the growing list of Ohio physicians who have been decorated is added the name of Capt. A. M. Adams, Lima, recently awarded the Soldier's Medal in Italy for exceptional heroism over and beyond the call of duty. The citation reads: "For heroism at great risk of his own life upon observing an Allied fighter aircraft crash and burst into flames, Flight Surgeon Capt. A. M. Adams rushed to the scene and heedless of intense heat, exploding ammunition and imminent danger of the aircraft exploding, made his way to the cockpit, freed the unconscious pilot and carried him to safety. By his courage and heroism in risking his life to save the life of another, this man has reflected great credit upon himself and the Armed Forces of the United States of America."

* * *

According to the Ironton Tribune, Major George Hunter, with an evacuation hospital unit in England, requested and received an absent voter's ballot for the May 9 primary. The story did not state whether the ballot was returned in time to be counted in the election, but, since Dr. Hunter is a former state senator, we'll bet that he saw to it that his vote was in there to be counted. We'll bet, too, that he has already requested his ballot for the November election. The procedure to be followed in making such a request was outlined in the June issue of The Journal and is repeated elsewhere in this issue.

* * *

A U. S. marine in a Naval hospital in the South Pacific recently wrote his mother in Waverly that his appendix was removed by Lieut. F. W. Nusbaum, formerly of nearby Chillicothe. Once again, it's a small world!

* * *

Lt. Robert Keating, Columbus, has reported for duty as a naval flight surgeon at Jacksonville, Fla. Dr. Keating was in plenty of action with the fleet at Salerno and Sicily.

* * *

Capt. Harold Schwartz, Cleveland, was one of the medical officers mentioned in a recent broadcast from England, describing the evacuation of wounded from the Normandy beach-head in C-47's of the Ninth Air Transport Command. The announcer stated that Dr. Schwartz was on the staff of a mobile hospital unit which was checking the wounded upon their arrival in England.

Lt. Comdr. E. R. Garvin and Lt. Bernard Botsch, Toledo, are with the Fifth Marine Division, Camp Pendleton, Oceanside, Calif.

* * *

Home on leave for 21 days after nearly a year in Persia, Lieut. Charles G. Brown, Mansfield, found Ohio Spring weather and green grass most acceptable. Dr. Brown, who was on duty at a dispensary in a port on the Persian gulf, reported that during the summer months the thermometer there registers 160 degrees in the heat of the day, dropping to slightly less than 100 degrees about 11 o'clock in the evening. He was to report at Camp Butner, N. C., upon the termination of his leave.

* * *

Major Paul Troup, Dayton, with the 37th Division, is reported to have completely recovered from wounds received in action at Bougainville on March 24.

* * *

Comdr. Orville M. Wright, Dayton, returned recently after 15 months in the South Pacific, has been assigned as staff medical officer at the Marine multi-engine training school, Cherry Point, N. C. Dr. Wright served in New Caledonia, New Hebrides, the Solomons and Bougainville, as medical officer with a marine dive bombing squadron.

* * *

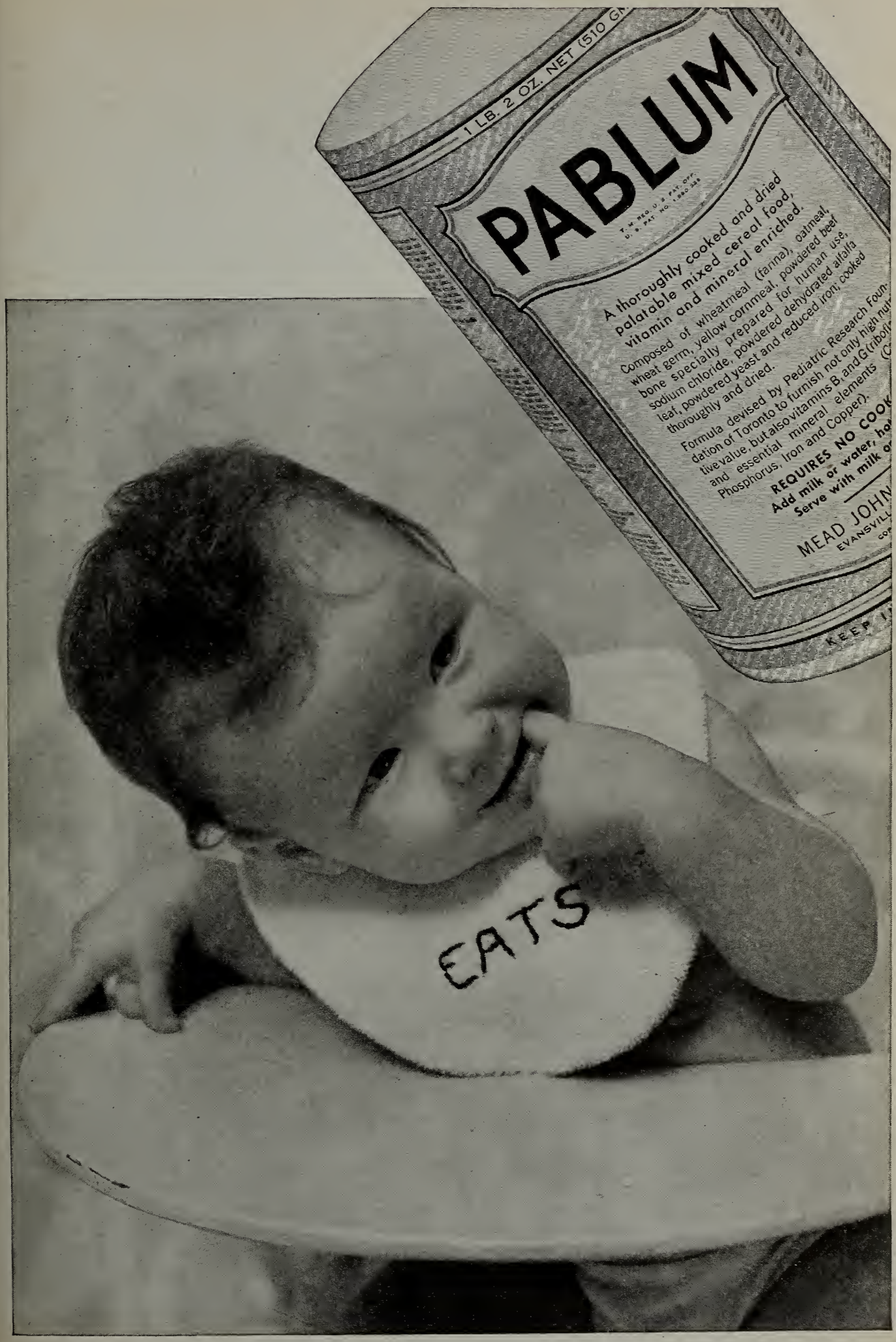
Capt. Carl Kumpe, Hillsboro, is executive officer of an Air Force post dispensary in England.

* * *

Also in England with the Air Force is Capt. Byron C. Stuhlman, Dayton, flight surgeon with a Mustang fighter group.

* * *

Recently tranferred within the U.S.A.: Capt. Russell L. Wiessinger, Sidney, Bowman Field, Louisville, Ky.; Capt. Russell F. Wiggers, Cincinnati, AAF, Geneva, Nebr.; Major H. Whirley, Coshocton, 110th Gen. Hosp., Camp Campbell, Ky.; Comdr. B. J. Wolpaw Cleveland, School of Aviation Medicine, NAS, Pensacola, Fla.; Capt. S. J. Shapiro, Warren, Camp Reynolds, Pa.; Capt. Irwin H. Stolzar, Cleveland, Ft. Hayes, Columbus; Lt. Franklin C. Schlueter, Cincinnati, Wright Field, Dayton; Lt. Comdr. Thos. F. Ross, Columbus, NTAS, Olathe, Kansas; Capt. J. B. Rayman, Toledo, Stark General Hospital, Charleston, S. C.; P. A. Surgeon (R) Harold J. Reese, USPHS, Youngstown, U .S. Maritime Service, Mobile, Alabama; Capt. Karl F. Ritter, Lima, AAB, Alliance, Nebr.;


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Maj. T. C. Allenbach, Columbus, Fletcher Gen. Hosp., Cambridge; Maj. Robert Thomas, Columbus, AAB, Great Falls, Mont.; Capt. R. E. Merrill, Delta, Sioux Falls, S. Dakota; Lt. Deane E. Mallett, Springfield, Army-Navy Gen. Hosp., Hot Springs, Ark.; Capt. Merritt K. Marshall, Findlay, c/o Ord. Officer, Sect. H, Greensboro, N.C.; Capt. R. C. Miller, Dayton, Kennedy Gen. Hosp., Memphis, Tenn.; Lt. Saul I. Krasne, Wickliffe, Camp Roberts, Calif.; Maj L. L. Lawrence, Canton, Ft. Bragg, N.C.; Capt. F. W. Kaylor, Bellefontaine, Army Medical Center, Washington, D.C.; Lt. A. J. Huesman, USNR, Cincinnati, Amphibious Training Base, Camp Bradford, NOB, Norfolk, Va.; Capt. James F. Jones, Cleveland, Hunter Field, Savannah, Ga.; Capt. S. E. Gates, Conneaut, Camp Polk, LaS.; Capt. G. L. Garvin, Blanchester, AAB, Atlanta, Ga.; Maj. Samuel L. Goldberg, Youngstown, Ft. Benning, Ga.; Lt. Christopher Colombi, Lyndhurst, Malden, Mo.; Lt. Ellis Flax, Cincinnati, Ft. Jackson, S.C.; Capt. Robert J. Emslie, Elyria, AFIS, Cleveland; Capt. H. B. Elliott, Springfield, Portland Air Region, Portland, Ore.; Lt. Comdr. J. L. Fisher, Youngstown, Camp Endicott, Davisville, R. I.; Capt. Ivan C. Johnson, Cincinnati, Sioux Falls, So. Dak.; Capt. C. W. Hunsche, Cincinnati, Camp Butner, N.C.

* * *

After nine months in the South Pacific, where he was wounded while participating in the Munda Campaign, Lt. William H. Gitman, Dayton, is now at the Station Hospital, Ft. Sill, Okla.

* * *

A change of address for Major Merwin R. Chappell, Athens, indicates that he is headed overseas with an auxiliary surgical group.

* * *

Major Maurice P. Cooper, Toledo, has been transferred from B.T.C. No. 10, Greensboro, N.C., to Scott Field, Ill., where he is chief of the Anesthesiology Section.

* * *

Major William F. Hunting, Cincinnati, writes that *The Journal* comes regularly but it has been taking a circuitous route to reach him in England, where he is with a station hospital.

* * *

Lt. H. G. Lehrer, Wadsworth, left the N.A.S. in Pensacola in May to return to the fleet. He is a squadron flight surgeon.

* * *

Writes Lt. Col. Arthur G. King, Cincinnati, en route, at sea, on his way back to the United States on rotation for the "exquisite luxury of 21 days' leave": "Having enjoyed receiving *The Journal* regularly, the least I can do in appreciation is to keep you informed of my whereabouts and status. My 28 months' tour of duty in the South Pacific hasn't actually been so bad, and it included a little intensive combat experience as an observer with the Marine Corps on the Guadalcanal beach-head. The rest of it was all staff work, first as medical inspector for the Task Force, then as Surgeon for New Caledonia when the Service Command was formed there, and lately as Island Surgeon for the Espiritu Santo in the New Hebrides when that base was organized."

* * *

Back in the United States for two months after a tour of duty in the Aleutians, Capt. Garry G. Bassett, Cleveland, now is with a field hospital unit in England.

* * *

From the Anzio beach-head, where he was with the Third Division Hdqrs. Dispensary, Capt. Harry G. Lieberman, Akron, wrote on May 23: "Have been a member of the Third Division since Spring of last year. Most of the time with the Third Medical Bn., in the African, Sicilian and Italian campaigns. Hope to see Rome soon." Expect by this time you have been there, doctor. Now, on to Berlin!

* * *

Capt. R. G. McCready, Akron, is enjoying his work in the urology department of the Regional Station Hospital, AAFTAC, Orlando, Fla. One of his associates there is Capt. F. L. Snyder, who graduated at Ohio State in 1935, and was practicing in Hollywood, Fla., before entering military service.

* * *

More new addresses within the United States: (There are many more outside the country, but they cannot be revealed.) Major Clarence T. Risley, Conneaut, Station Hosp., New Castle AAB, Wilmington, Del.; Lt. Clarence P. Somsel, Dayton, ASFTC Consultation Service, Mississippi Ordnance Plant, Flora, Miss.; Lt. Comdr. R. C. Schneble, Dayton, c/o Commandant, Twelfth Naval District, San Francisco; Capt. Leo M. Levin, Cleveland, Army and Navy General Hospital, Hot Springs, Ark.; Lt. Howard Lauer, Dayton, Med. Det., ASC, San Bernardino, Calif.; Major Fred R. Kelly, Cleveland, Hdqrs. Second Army, Memphis, Tenn.; Lt. Col. H. E. Harman, Chillicothe, MDRP, ASFTC, Camp Grant, Ill.; Capt. John A. Glorioso, Lima, Station Hospital, Camp Maxey, Texas; Lt. Jas. A. Carnes, Massillon, Army Medical Center, Washington, D. C.; Major Daniel E. Earley, Cincinnati, Nichols General Hospital, Louisville, Ky.

* * *

News about Cleveland medical officers: Major Spencer Braden, in the neurosurgical section of Nichols Gen. Hosp., Louisville, Ky.; Lt. Col. P. F. Briola, malaria patient at the Baxter Gen. Hosp., Spokane, Wash.; Lt. Col. W. B. Johnston, with a medical bn. on the Anzio Beach (probably



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'IVYOL' poison-ivy extract contains purified principles of poison ivy (1:1000) in sterile olive oil. Administration by deep, intramuscular injection is relatively painless because of the bland vehicle.

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away north of there by now); Lt. Stanley Matuszewski, living in a tent in Corsica; Major Louis Pillersdorf, in charge of neuropsychiatry at Battey Gen. Hosp., Rome, Ga.; Capt. R. R. Richards, in New Guinea with an air depot group; Major Marvin G. Sadugor, on the same island in the South Pacific for two years, with a Sig. A.W. Bn.; Comdr. S. C. Lind, chief of surgery, at U.S.N. Hosp., Santa Margarita, Oceanside, Calif.; Capt. R. J. McCafferty, with a hospital unit in Burma, "has been on a Cook's Tour, collecting two campaign ribbons and one star". 5

* * *

Announcement of the promotion to Colonel of Dr. Russell J. Caton, Bucyrus, who has been on duty with the 37th Division in the South Pacific for over two years, recalls that he also had a distinguished military record in World War I, in which he was a captain in the 146th infantry, with action at Ypres-Lys and the Meuse-Argonne.

* * *

Recently returned to the United States after a year in the South Pacific, Lt. Comdr. Meyer A. Zeligs, Cincinnati, writes: "I had the good fortune to have had many interesting medico-military experiences in the field, especially the psychiatric casualties of war which I saw and treated in abundance. I am now in charge of neuropsychiatry at the Marine Barracks, Klamath Falls, Oregon. This is a newly completed, beautifully situated, large rehabilitation center, which the Navy has constructed for the rehabilitation of marines returned from combat. It offers an excellent opportunity for first-hand study and research in psycho-somatic medicine, particularly in regard to the tremendous problem of combat fatigue, chronic malaria and filariasis."

* * *

The class of aviation medical examiners graduated May 17 following the course on aviation medicine at Randolph Field, Texas, included the following Ohio medical officers: Capt. Russell C. Bane, Chillicothe; Maj. Earl W. Burgner, Akron; Lieut. Robert B. Burrell, Columbus; Capt. Harold B. Elliott, Springfield; Major Norbert S. Greene, Cleveland; Major Herman H. Ipp, Youngstown; Lieut. Francis W. McCoy, Columbus; Capt. Lawrence B. Mehl, Cuyahoga Falls; Capt. Robert E. Merrill, Delta; Lieut. Col. John Noll, Jr., Youngstown; Capt. Karl F. Ritter, Lima; Capt. David J. Roberts, Akron; Major Harold D. Waltz, Sandusky.

* * *

According to the UP, Captain William G. Wu, former resident physician at St. Marys Hospital, Cincinnati, is with an American hospital unit attached to the Chinese expeditionary forces on the Salween River front.

An Associated Press story from Portsmouth, Va., gives a well-deserved boost to Comdr. Judson D. Wilson, Columbus, chief of orthopedic surgery at the U. S. Naval Hospital there. He has been in the service since shortly after Pearl Harbor, and apparently has been extremely busy since that time practicing his specialty.

* * *

Major Dorrance S. James, Delaware, is assistant chief of the surgical service of the 111th Evacuation Hospital, Camp Swift, Texas. Capt. Edward G. Ditch, Caldwell, is with the same outfit.

* * *

The twin Kirk brothers from Columbus—Major Robert C. and Major Gilman D.—recently had a one-day reunion in "one of England's loveliest places". They are attached to general hospital units there.

* * *

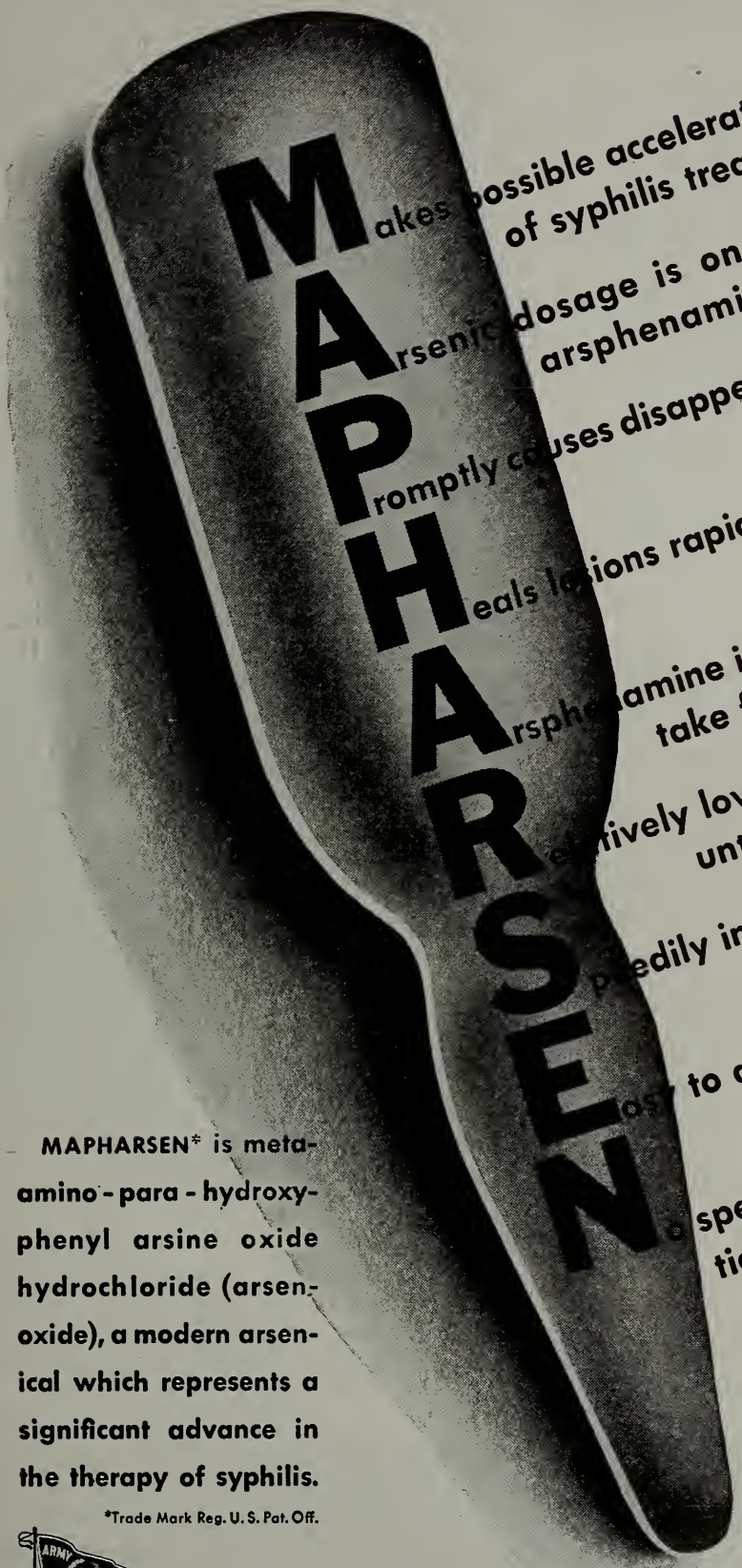
Lieut. Elmer J. Kirkland, a pilot in the Army Air Force, and son of Dr. Clyde W. Kirkland, Bellaire, former Councilor of the Ohio State Medical Association, has been awarded a Silver Star by Lieut. Gen. George C. Kenney, commander of the Allied air forces in the Southwest Pacific, for gallantry in action at Kavieng, New Ireland on Feb. 15, after the B-25 of which he was co-pilot was damaged while bombing the Japanese base and forced to land two miles from shore. The citation said: "After extricating himself from the wrecked aircraft Lieut. Kirkland learned that a crew member was missing. He promptly re-entered the sinking plane and removed the injured man to a life raft. A moment later he rescued another crew member who could not swim and was floundering in the water. Lieut. Kirkland's gallantry in disregarding his own safety while rescuing fellow airmen from certain death is in keeping with the finest traditions of the service."

* * *

These Ohio docs do get around! From Russia comes word that Major Paul A. Stoodt, Mansfield, did an emergency appendectomy on one of the American flyers who landed there after the first shuttle-bombing trip in that area. Dr. Stoodt is chief of surgery in a field hospital unit.

* * * *

The general hospital unit, of which Maj. W. R. Hochwalt, Dayton, is chief of the orthopedic section, is settling down in Australia after an ill-starred attempt to establish itself in New Guinea. Officers and enlisted men of the outfit, together with the hospital's equipment, were headed for an advanced location in the New Guinea jungles; but, somewhere between the Australian mainland and their destination, their boats ran onto reefs, necessitating transfer of



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men and equipment to other boats and back to Australia. By the time the hospital reorganized, another general hospital unit had taken their place in New Guinea, and they were given the job of establishing their hospital in Australia.

* * *

Lt. Col. Hobart L. Mikesell, West Liberty, is Hollywood-bound! He has been ordered by the War Department to report to the Warner Bros. studio for duty in the production of a special film, sponsored by the War Department, portraying for the general public the part played by the Medical Corps in caring for wounded soldiers. Dr. Mikesell is well-qualified for the assignment, as he was a medical officer with the 37th Division in the South Pacific for nearly two years. He was invalided home, and after a period of hospitalization, completed a six weeks' course in internal medicine at the Mayo Clinic. During World War I he served in the Air Corps, and has been interested in motion picture photography and its use in teaching.

* * *

A graduate of Western Reserve University School of Medicine in 1938, Capt. John E. Carter, surgeon for the 1st Battalion, 145th Infantry, was killed in action on Guadalcanal, July 22, 1943, according to the June issue of *The Journal of the Indiana State Medical Association.* Dr. Carter was a resident at the Methodist Hospital, Indianapolis, when he entered the service.

* * *

Comdr. Max E. Lapham, formerly executive officer of the Procurement and Assignment Service in Washington, D.C., is now stationed at the Naval Hospital, San Diego, Calif. His successor is Dr. Paul C. Barton, who was acting executive officer during Dr. Lapham's serious illness.

* * *

Major C. F. Barber, Felicity, assistant division surgeon, with an infantry division in New Guinea, writes that he looks forward to each issue of *The Journal* eagerly. He says: "We are counting on the men at home to protect our interests, and I for one sincerely believe that you are doing just that".

* * *

After 28 months in the Central and South Pacific Islands, Capt. Alton W. Behm, Chardon, anticipates a visit back home soon.

* * *

Lt. Col. Charles Berns, Cleveland, with an evacuation hospital unit somewhere outside of the U.S.A., is chief of the surgical section, which includes the following Ohioans: Maj. H. M. Crumley, Chillicothe; Maj. J. L. Plymale, Marion; Capt. Gordon T. Wagner, E. Cleveland, and Capt. Walter A. Hoyt, Jr., Akron.

Capt. Melvin Brody, Canton, formerly at Camp Barkeley, Texas, now has a New York APO, and Capt. Joseph J. Fink, Cleveland, formerly at the same spot in Texas, now has a San Francisco APO.

* * *

Lt. Joseph Colvin, Cincinnati, is with an Epidemiology Unit, c/o FPO, San Francisco.

* * *

The Station Hospital at Camp Crowder, Mo., is the new assignment of Lt. Aaron S. Canowitz, Columbus.

* * *

Capt. Weldon E. Diller, Rawson, recently returned from Australia, is at the Station Hospital, Ft. Lewis, Wash.

* * *

Lt. Col. Paul H. Jones, Stockdale, is with a replacement depot in England.

* * *

Capt. James M. Harkey, overseas for 15 months, expresses appreciation for his 1944 membership card and *The Journal*, which he received at an "isolated station hospital" in India. He continues: "I've talked with men who have returned from the combat areas and they have nothing but praise for the generous services of the medics. I believe there's no single group that wants more to get this over and return to civilian status than the members of the Medical Corps."

* * *

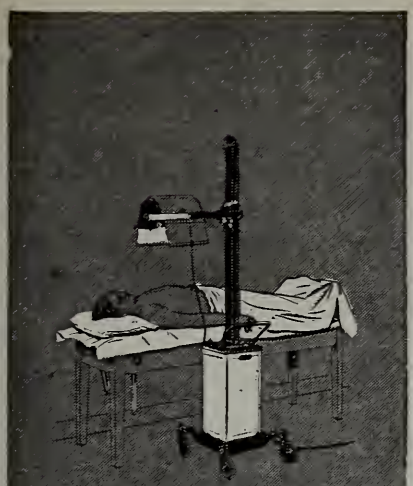
Comdr. E. R. Hammersley, naval flight surgeon with a scouting squadron in the South Pacific for 7 months, was recently made a three-striper. He writes that he was glad to see the names of two other Ohioans on the same promotion list: Comdr. Paul L. Yordy, Dayton, U.S. Naval Hospital, San Diego and Comdr. Judson D. Wilson, Columbus, U. S. Naval Hospital, Portsmouth, Va.

* * *

Recent additions to the Ohio delegation in England include Capt. Louis B. Katz, Dayton, who is attached to a medical clearing company, and Capt. Chester A. Morgan, Van Wert, with the medical detachment of a field artillery battalion.

* * *

Lt. Comdr. Richard M. Forsythe, a native of Cleveland and graduate of the Western Reserve University School of Medicine in 1937, died of wounds received in a battle in the South Pacific on March 30. On duty with the Marines in the South Pacific for over two years, Dr. Forsythe was resident surgeon at Grasslands Hospital, Westchester County, N.Y., prior to entering the service. Assigned to the First Marine Division, he was with the Devil Dogs throughout the campaign on Guadalcanal. Circumstances of his







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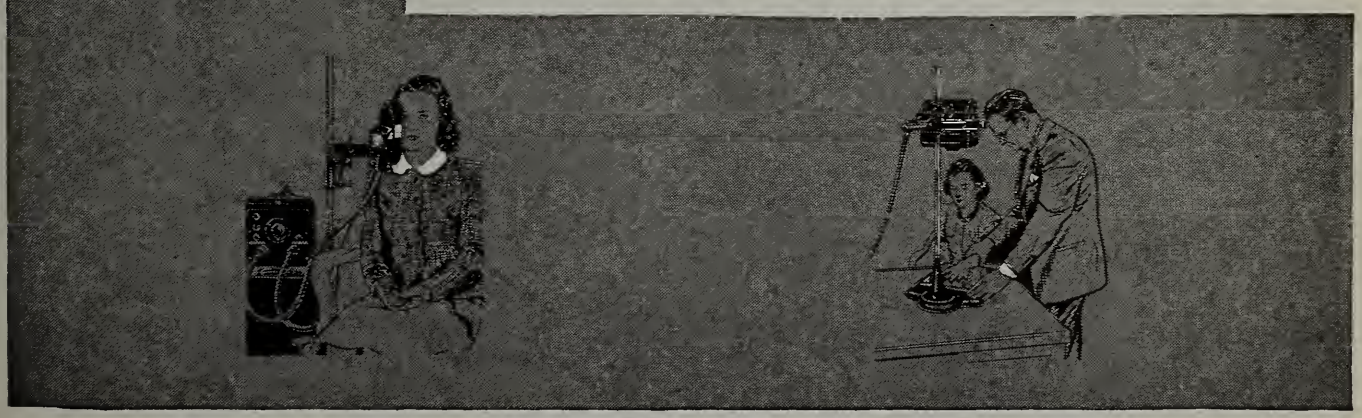
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death are related as follows in the May issue of the magazine of The Fraternity of Phi Gamma Delta, of which he was a member: "Dr. Forsythe was seriously wounded in the battle for the Talasea airdrome. A Jap mortar scored a lucky hit near the field hospital a few hours after the Marines made their successful landing. After having his wound dressed, Dr. Forsythe refused to quit. He continued working with the other wounded until he collapsed an hour and a half later. That night he hovered between life and death, his colon pierced by a shrapnel sliver. He died on March 30."

* * *

A destroyer-escort, the U. S. S. Pratt, was launched at Range, Texas, June 1, honoring an Ohio physician and his son who gave their lives in the campaign for the Solomon Islands. The sponsor was Mrs. Malcolm M. Pratt, Bellefontaine, widow of Lt. Comdr. Pratt, M.C., U.S.N.V.R., and mother of 1st Lt. John L. Pratt, U.S.M.C.. Accompanying the sponsor was her daughter, Jane; her husband's brother, Dr. Robert B. Pratt, and his wife, all of Bellefontaine. Lt. Comdr. Pratt was reported missing following a landing operation with a Marine detachment at Guadalcanal on the night of August 12, 1942, and was presumably killed in action at that time. The son also was killed in action with the Marines on Guadalcanal on Jan. 22, 1943.

* * *

Lt. Comdr. Edwin S. Shane, Circleville, formerly stationed at Louisville, Ky., is now on sea duty in the Pacific.

* * *

Lt. Col. H. E. Wilkinson, Van Wert, V-mails greetings from Italy, where he is CO of a field hospital unit. He writes: "It has been a pleasure to receive *The Journal* and to hear from old friends scattered over the globe. I have been commanding this hospital since January, 1943, and we celebrated our first year overseas on April 29. This unit is a front-line unit, doing the surgery at the clearing stations on all cases whose wounds are so serious that they cannot be evacuated to the rear. Our nurses, doctors and enlisted men are doing a wonderful job in bringing medical and surgical care to the badly-wounded soldier."

* * *

After 19 months at a Naval Hospital in Auckland, New Zealand, Lt. Comdr. Chas F. Ward, Cleveland, is now stationed at Purdue University, LaFayette, Ind.

* * *

Dr. James A. Doull, professor of public health at Western Reserve University School of Medicine, Cleveland, returned to his classroom recently from London, where he had been since March as medical consultant to the United Nations Relief and Rehabilitation Administration.

* * *

The general hospital unit in England commanded by Col. N. H. McNerney, Cleveland, was the subject of a very complimentary article appearing in the *Cleveland Plain Dealer* recently, written by Roelif Loveland, the P. D.'s war correspondent.

* * *

Battalion medical officer with an amphibious tank battalion at Fort Ord, Calif., is the tough assignment of Dr. Paul E. Foy, Troy.

* * *

Lt. Comdr. Earl M. Smith, Dayton, previously at the Naval Dispensary, Washington, D.C., is now stationed in England with a Naval Air Service Unit.

* * *

An AP wirephoto from a Liberator bombing base in England pictured a Broad-and-High reunion of several Columbusites, including Capt. John P. Urban, flight surgeon.

* * *

As a result of an Army decision to discontinue specialized training in veterinary medicine, 127 students in that course at Ohio State University were honorably discharged from Army duty on June 19. Sixty-two seniors were permitted to remain in school with their Army status until their graduation September 1. Lower classmen were given their choice of assignment to a ground force unit or of discharge and return to the jurisdiction of their selective service boards. Eleven elected to remain in the Army.

Refresher Course Dates Set

The University of Illinois College of Medicine announces that its Fall didactic and clinical refresher course for specialists in otolaryngology will be held from September 25 to 30, inclusive. The fee for the course is $50.00 Since registration is limited to 25, applications should be filed as early as possible. Write for information to Department of Otolaryngology, University of Illinois, College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Board Examinations

The American Board of Ophthalmology, the executive office of which is now located at Cape Cottage, Maine, has announced examinations for 1945 as follows: Los Angeles, January, deadline for applications, October 1; New York City, June, deadline for applications December 1; Chicago, October, deadline for applications, April 1.

Cincinnati—Dr. J. L. Tuechter has been reelected president of the Heart Council of the Community Chest.

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In Memoriam

Roy Wood Adkins, M.D., Ft. Lauderdale, Fla.; Ohio State University College of Medicine, 1911; aged 57; member of the Ohio State Medical Association and the American Medical Association; died May 27. Dr. Adkins practiced in Dayton for 27 years, retiring in 1941 because of ill health. He was a member of the Masonic Order. Surviving are his widow, a daughter, a son and four brothers.

Charles G. Blackwelder, M.D., New Springfield; University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1895; aged 76; died May 18. Dr. Blackwelder practiced in Mahoning County for nearly 50 years. Two sisters and a brother survive.

John Charles Bowman, M.D., Genoa; Columbus Medical College, 1890; aged 81; died May 30. Dr. Bowman practiced in Ottawa County for 54 years. His widow survives.

Stanley James Bown, M.D., Richwood; Starling Medical College, Columbus, 1898; aged 72; former member of the Ohio State Medical Association and the American Medical Association; died May 16. Dr. Bown was located in Richwood for 36 years, and previously practiced at Claiborne. He was a member of the Methodist Church and the Masonic Order. Surviving are his widow, two daughters, a son and two brothers.

Oliver Llewellyn Butterick, M.D., Toledo; New York University Medical College, 1887; aged 82; died May 3. Dr. Butterick practiced in Toledo for 35 years. He is survived by his widow, a daughter and a son.

Homer Jury Davis, M.D., Newark; Rush Medical College, Chicago, 1904; aged 69; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; died May 6. A native of Licking County, Dr. Davis had been prominent professionally and in community affairs there for nearly 40 years. He had been chief of staff of the Newark City Hospital for 20 years and was a past-president of the Licking County Medical Society. Dr. Davis was a member of Beta Theta Pi, Phi Rho Sigma and the Rotary Club. A daughter survives.

Edwin M. Stanton Edwards, M.D., Trinway; Baltimore Medical College, Md., 1898; aged 72; member of the Ohio State Medical Association and Fellow of the American Medical Association; died June 11. Dr. Edwards practiced in Trinway for 30 years and in West Carlisle for 16 years. He was a member of the Methodist Church. Two sisters survive.

John Franklin Iden, M.D., Dresden; University of Louisville School of Medicine, Ky., 1894; aged 76; member of the Ohio State Medical Association and the American Medical Association; died June 11. Dr. Iden practiced in Mt. Sterling for eight years and in Dresden for 42 years. He was a member of the Masonic Order and the Methodist Church. Surviving are a son, a daughter, and three brothers, including Dr. O. L. Iden, Chillicothe.

Theron Skeels Jackson, M.D., Cleveland; Western Reserve University School of Medicine, Cleveland, 1913; aged 59; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; died May 31. A native of Cleveland, Dr. Jackson practiced there for 30 years. During World War I he served in France with the Lakeside Unit as a captain in the Medical Corps. Dr. Jackson was a member of the staffs of Huron Road and Woman's hospitals. Surviving are his widow, a daughter and his parents.

Reuel Hammond Jones, M.D., New Carlisle; Ohio Medical University, Columbus, 1905 aged 69; member of the Ohio State Medical Association and Fellow of the American Medical Association; died May 17. Except for a few years when he was located in Dayton, Dr. Jones spent most of his professional life in New Carlisle. His widow and a sister survive.

Jerome Howard King, M.D., Ashland; Cleveland Homeopathic Medical College, 1894; aged 74; died May 13. After practicing medicine in Ashland for 10 years, Dr. King purchased the Ashland Drug Company and continued in that business until his retirement in 1931. A sister survives.

Elliott D. Moore, M.D., New Philadelphia; Western Reserve University School of Medicine, 1888; aged 80; former member of the Ohio State Medical Association and the American Medical Association; died June 15. A practicing physician for 53 years, Dr. Moore retired in 1941. He was located in Moorefield, Harrison County, before moving to New Philadelphia. A daughter and a brother survive.

John Jay Kinney, M.D., Wooster; University of Wooster, Medical Dept., Cleveland, 1889; aged 79; member of the Ohio State Medical Association and the American Medical Association; died May 14, in St. Augustine, Fla. After prac-

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ticing at near-by Creston and Canaan Center, Dr. Kinney located in Wooster in 1893, and except for short periods of study in Europe between 1904 and 1913, spent his life in practice there. He was founder of a hospital there in 1904, known as the Kinney Hospital, which was incorporated as the Wooster Community Hospital last year. Dr. Kinney was a member of the Elks and a former Kiwanian. His widow, a daughter anad two sons survive.

John Thomas Murphy, M.D., Toledo; Toledo Medical College, 1906; aged 59; member of the Ohio State Medical Association; Fellow of the American Medical Association; Diplomate of the American Board of Radiology; Fellow of the American College of Physicians; member of the American Roentgen Ray Society, secretary from 1928 to 1931 and president in 1934; Fellow of the American College of Radiologists, president in 1935; member of the Radiological Society of North America and the American Radium Society; died June 15. Nationally renowned in his specialty, Dr. Murphy practiced in Toledo for 37 years. He had been director of the radiological department of St. Vincent's Hospital since 1917, and was consulting radiologist at Lucas County Hospital. Dr. Murphy was ever active in behalf of the organized medical profession. He was a past-president of the Toledo Academy of Medicine, and had been a legislative committeeman and delegate to the Ohio State Medical Association. Dr. Murphy was elected secretary of the Section on Radiology of the American Medical Association in 1931, and continued in that capacity until his death. He had made many contributions to the radiological field through scientific articles and exhibits. His hobbies were aviation and athletics. Dr. Murphy was one of Toledo's pioneer airplane pilots. Long before pilots were licensed he flew his own plane and maintained an active interest in aviation. On the track team while in college, he was a member of the American Amateur Athletic Association and president of the Toledo Figure Skating Club. He was a fine skater, and also excelled in golf. Dr. Murphy was a member of the Knights of Columbus, Elks, Rotary, Toledo and Catawba Cliffs Beach Club, and an honorary member of the Toledo Notre Dame Society. Surviving are his widow, three daughters, a son and a sister.

Rudolph Jerome Price, M.D., Dayton; University of Michigan Medical School, Ann Arbor, 1923; aged 49; member of the Ohio State Medical Association and the American Medical Association; Diplomate of the American Board of Radiology; Fellow of the American Roentgen Ray Society, the Radiological Society of North America and the American College of Radiology; died June 8, following an automobile accident. Dr. Price had practiced his specialty in Dayton since 1924. Surviving are his widow and two sons.

Walter McClellan Smalley, M.D., Dayton; Ft. Wayne College of Medicine, Ind., 1889; aged 82; died May 1. Medical supervisor of the Miami Conservancy District from 1918 to 1922, Dr. Smalley previously practiced in Ohio City and Upper Sandusky for 30 years. His widow, a son and two daughters survive.

Edward Elmer Smith, M.D., Columbus; Ohio State University College of Medicine, 1910; aged 58; member of the Ohio State Medical Association and the American Medical Association; died June 18. Coroner of Franklin County since 1930, Dr. Smith practiced in Columbus for over 30 years. During World War I, Dr. Smith served in France with the 146th Ambulance Company, 112th Sanitary Train, 37th Division, and was a major at the close of the war. In peace time he was active in the Ohio National Guard, and was commissioned a Lieut. Col. in the Ohio State Guard shortly after the outbreak of World War II. Dr. Smith was a member of the Columbus Board of Health from 1925 to 1937, and was president in 1932. He was a past-commander of the Franklin Post of the American Legion and a past exalted ruler of the Columbus Lodge of Elks. Dr. Smith was a member of the Masonic Order, the Lions Club and the Lutheran Church. Surviving are his widow, a daughter and three sisters.

Farkas Wolfgang Steiner, M.D., Akron; University of Budapest, Hungary, 1912; aged 56; former member of the Ohio State Medical Association and the American Medical Association; died May 5. Dr. Steiner retired a year ago because of ill health, after having practiced in Akron for nearly 25 years. He was a medical officer in the Hungarian army in World War I. A former vice-president of the Akron District Zionist Organization, he was active also in various other Jewish fraternal and welfare organizations. His widow survives.

Oscar Theodore Thomas, M.D., Cleveland; University of Pennsylvania School of Medicine, Philadelphia, 1892; aged 75; former member of the Ohio State Medical Association and the American Medical Association; died June 3. A practicing physician in Cleveland for over 50 years, Dr. Thomas taught gynecology at Western Reserve for 40 years. He was a member of the staff of Woman's Hospital, and was formerly on the staffs of City and Charity hospitals. Dr. Thomas was a member of the Pasteur Club, composed of Cleveland specialists. His widow and a daughter survive.

Edward Joseph Tulleys, M.D., South Salem; Hahnemann Medical College and Hospital, Chi-

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Each disease is discussed from the point of view of the essential laboratory data required for diagnosis. An index of diseases is included.

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cago, 1899; aged 70; member of the Ohio State Medical Association and the American Medical Association; died June 1. Dr. Tulleys practiced in South Salem and Ross County for 45 years. Active in church and community affairs, he had served as mayor of South Salem. Dr. Tulleys was a member of the Greenfield Elks and Masonic Lodges and the Methodist Church. He is survived by his widow and a daughter.

McClellan Vance, M.D., London; Eclectic Medical College, Cincinnati, 1887; aged 82; died May 8. Dr. Vance retired a few years ago, after having practiced in London for 40 years. A daughter and a son survive.

David I. Wolfstein, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1888; aged 82; former member of the Ohio State Medical Association, American Medical Association and the American Neurological Association; died June 7. Professor-emeritus of psychiatry at the University of Cincinnati, Dr. Wolfstein retired 10 years ago after having practiced in Cincinnati for 45 years. He was president of the City Club from 1910 to 1912, a trustee of the University of Cincinnati from 1912 to 1921 and a trustee of Hebrew Union College. Surviving are his widow and three daughters.

Officers Elected By Nurses

Officers of the Ohio State Nurses' Association elected May 20, 1944, at the annual convention in Columbus, were:

President, Mrs. Helen Haughton, Columbus; first vice-president, Mrs. Ivalu S. Brown, Dayton; second vice-president, Miss Elgie Wallinger, Columbus; secretary, Mrs. Edna W. Viets, Youngstown; treasurer, Miss Freda Gooding, Steubenville; trustees, Miss Sue Z. McCracken, Cleveland, and Sister M. Alfreda, Columbus; general secretary, Mrs. Elizabeth P. August, Columbus.

The following section officers were selected:

Section on Nursing Education: Chairman, Miss Freda Gooding, Steubenville; vice-chairman, Miss Alice Dorian, Cleveland; secretary, Miss Anne Yelton, Dayton.

Section on Public Health Nursing: Chairman, Miss Bertha Henderson, East Cleveland; vice-chairman, Miss Florence Schrieber, Cincinnati; secretary, Miss Florence Johnston, Columbus.

Section on Industrial Nursing: Chairman, Miss Catherine Denning, Columbus; vice-chairman, Miss Virginia Moore, Coshocton; secretary, Miss Celia May, Youngstown.

Section on Private Duty Nursing: Chairman, Miss Helena Tracy, Cincinnati; vice-chairman, Mrs. Margaret Lundberg, Cleveland Heights; secretary, Mrs. Frances M. Wonders, Toledo.

Columbus—Dr. W. D. Murphy is the new president of the Adams County Society of Columbus.

Physician Population of the U.S. Increased By 2,570 Last Year

There were 5,952 additions to the medical profession in 1943, according to the data presented in the forty-second annual compilation of medical licensure and allied statistics by the Council on Medical Education and Hospitals of the American Medical Association and published in *The Journal* of the A.M.A. for May 13.

The report says that the number of physicians removed by death in 1943 was 3,382. "It would appear, therefore", the report says, "that the physician population in the United States last year was increased by 2,570. In view of the accelerated curriculum with two classes graduating from most schools in 1943, one might expect that additions to the profession should be considerably higher. This in reality is the case at the present time. . . .

"Estimated figures indicate on Feb. 1, 1944 the number of physicians in continental United States, including those licensed in 1943, was 186,496. Excluding physicians who are in military service, engaged in full time hospital work, retired, not in practice or engaged in full time teaching, there remain about 100,000 physicians in private practice, some of whom are part time teachers. . . ."

Throughout 1943, 8,392 graduates were examined for licensure, of whom 7,478 passed and 914 failed. Of 6,427 graduates of approved medical schools in the United States only 1.5 per cent failed. Of 76 graduates of approved Canadian schools, 15.7 per cent failed; of 101 who graduated from approved schools no longer operating, 5.0 per cent failed; of 1,031 graduates of faculties of medicine located in countries other than the United States and Canada, 49.8 per cent failed. There were 38.4 per cent failures among 757 graduates of unapproved schools.

New Directory of Specialists

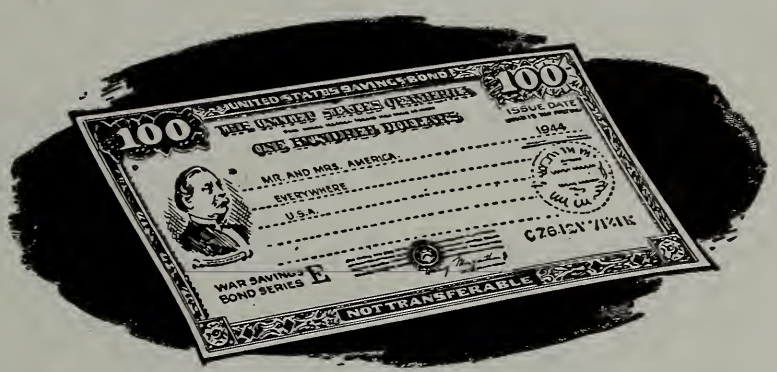
The third edition of the Directory of Medical Specialists listing names and biographic data of all persons certified by the fifteen American Boards is to be published early in 1945. Collection of biographic data of the diplomates certified since the 1942 edition, and revision of the older listings in that volume are now going forward rapidly. Diplomates are requested to make prompt return of their notices regarding their biographies as soon as possible after receiving the proper forms from the publication office soon to be mailed to them.

Coshocton—New staff officers of City Hospital are: Dr. A. P. Magness, chief; Dr. R. F. Hopkins, assistant chief, and Dr. Harold W. Lear, secretary.

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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

An all-day session of the Adams County Medical Society was held at the Museum, Serpent Mound State Park, June 21. The following program was presented: "Some Phases of Sanitation", Dr. Otto K. Engelke, Ann Arbor, Mich.; "Diarrhoeas in Children", Dr. Harold F. Downing, Cincinnati; "Medicine in the South Pacific", Capt. J. G. Inman, formerly of Manchester, now home on leave. Members of the society, visiting physicians, and their families were guests of Dr. R. L. Lawwill and the staff of the Adams County Health Department at the meeting.—H. L. Sproull, M.D., secretary.

BUTLER

Dr. Robert Rothenberg, Cincinnati, chairman of the Committee on Medical Service Plans of the Ohio State Medical Association and chairman of the Medical Economics Committee of the Cincinnati Academy of Medicine, spoke on "A Medical Service Plan for Butler County", at a meeting of the Butler County Medical Society, May 25, at Middletown Hospital. Mr. Jas. E. Stuart, executive vice president of the Hospital Care Corporation of Cincinnati, also addressed the meeting.—Azel Ames, M.D., president.

CLINTON

"After the War, What?", was the topic discussed by Dr. Robert Conard at a meeting of the Clinton County Medical Society, June 6, at Wilmington. A resolution was passed approving in principle the project of the county building a general hospital with public funds, if found feasible.—R. W. DeCrow, M.D., secretary.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

MONTGOMERY

The Montgomery County Medical Society met at the Dayton Country Club on June 7. Following an afternoon of golf and an excellent dinner, Dr. Conrad Lamb, of the senior surgical staff of Henry Ford Hospital, Detroit, spoke on "Treatment of Burns".—Don Paden, M.D., president.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

MAHONING

Dr. Genevieve Delfs gave an illustrated talk on "Nutritional Diseases", at a meeting of the Mahoning County Medical Society, June 20, at the Youngstown Club.—Bulletin.

STARK

Dr. Louis Mark, Columbus, spoke on "Diseases of the Chest", at a meeting of the Stark County Medical Society, May 17, at Mercy Hospital, Canton.—News clipping.

SUMMIT

At a meeting of the Summit County Medical Society, June 6, at City Hospital, Akron, Dr. Charles A. Doan, professor of medicine and director of medical research, Ohio State University College of Medicine, spoke on blood diseases and the various recent developments in hematological procedures as aids in general diagnosis.—Bulletin.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

MUSKINGUM

At a meeting of the Muskingum County Academy of Medicine, June 7, at the University Club, Zanesville, there was full discussion of the relationship between physicians and the Farm Security Administration.—Beatrice T. Hagen, M.D., secretary.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D. PORTSMOUTH)

SCIOTO

At the regular monthly meeting of the Hempstead Academy of Medicine, June 12, at Portsmouth General Hospital, the members enjoyed a discussion by Major Christopher Leggo, chief of the Industrial Hygiene Division of the State Department of Health, on the subject "Fundamentals of Industrial Health Programs". Dr. Leggo explained the manner in which modern industrial medical practice has been able to correlate its function of employee guidance and rehabilitation with the basic interests of public health workers and the family physician. Proper limiting areas for each of these three approaches were pointed out, and cooperation among those in these fields stressed.—T. W. Frame, M.D., secretary.

Eleventh District

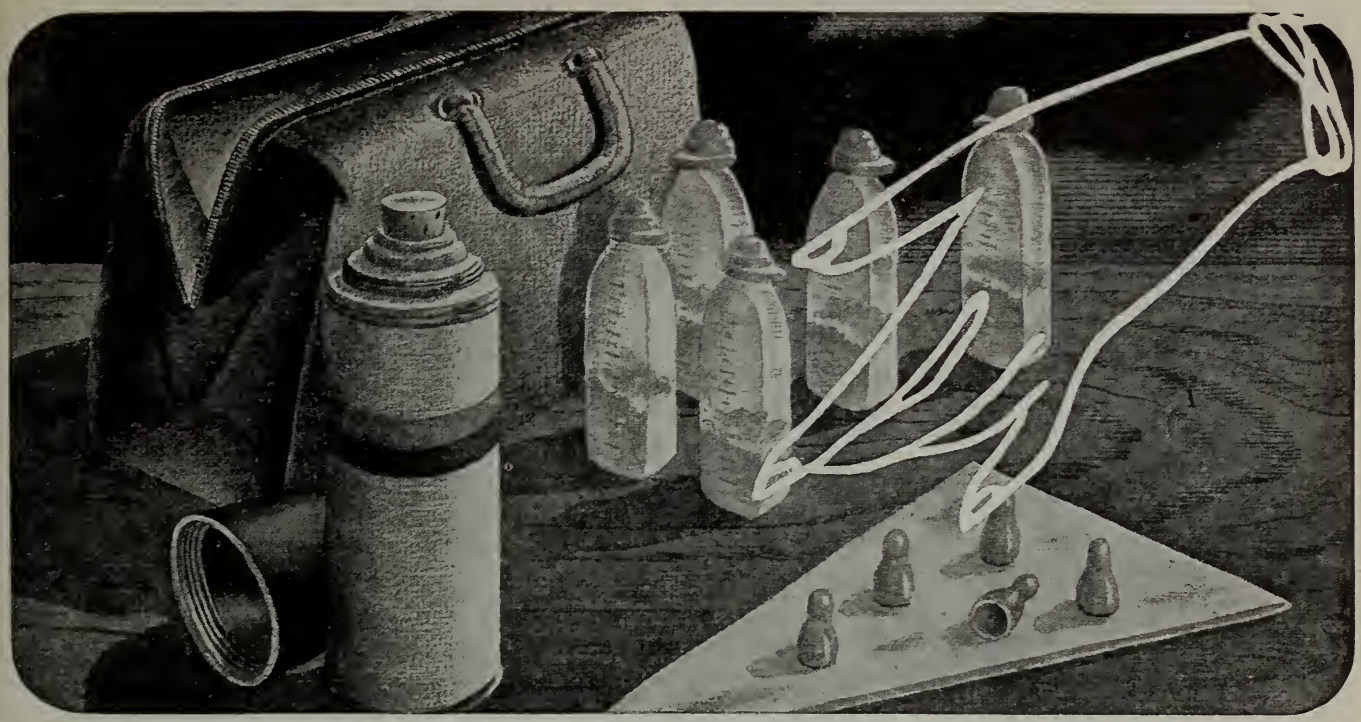
(ROSS M. KNOBLE, M. D., SANDUSKY)

ASHLAND

Dr. E. Perry McCullagh, Cleveland, spoke on "The Hormone Treatment of Menstrual Disorders", at a meeting of the Ashland County Medical Society, May 19, at the Ashland Country Club.—News clipping.

LORAIN

Dr. Floyd Mowry, Cleveland, spoke on "Com-



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plications of Pregnancy" at a meeting of the Lorain County Medical Society, June 13, at the Lorain Country Club.

RICHLAND

"X-ray Therapy—Deep and Superficial", was the subject of an address made by Dr. C. J. Dundon, department of roentgenology, Lakeside Hospital, Cleveland, at a meeting of the Richland County Medical Society, June 15, at Shelby Memorial Hospital.

Woman's Auxiliary News

LUCAS

At a meeting of the Woman's Auxiliary to The Academy of Medicine of Toledo and Lucas County, May 16, at Toledo, the following new officers were elected: Mrs. W. F. Maxwell, president; Mrs. F. B. McNierney, president-elect; Mrs. J. L. Stifel, vice president; Mrs. J. E. Minns, corresponding secretary; Mrs. H. D. Brown, secretary; Mrs. F. B. Ficklin, treasurer; Mrs. N. W. Kaiser, assistant treasurer. The Auxiliary has had an outstanding year, with a total membership of over 200. Mrs. W. W. Beck is the retiring president. Two outstanding projects were: assistance in the Academy's library, under the direction of Mrs. E. B. Gillette, and the War Bond Drive committee, under Mrs. H. H. Stevens.

MARION

Mrs. J. A. Dodd was elected president of the Woman's Auxiliary to the Marion Academy of Medicine when the members closed their second year with a luncheon meeting May 20, at the Manor House, Marion. She succeeds Mrs. Harold K. Mouser. Other officers are: Mrs. Carl W. Sawyer, vice president; Mrs. Richard Morgan, secretary; Mrs. Frederick T. Merchant, corresponding secretary, and Mrs. C. G. Smith, treasurer.

MAHONING

The Woman's Auxiliary to the Mahoning County Medical Society held a very successful bridge party at the Woman's City Club, Youngstown, May 11. Proceeds will be used for war service activities. Mrs. W. O. Mermis, chairman, was assisted by Mrs. Donald Gross, co-chairman, and a large cooperative committee.

Canton—Dr. John Van Dyke pointed out the dangers of the Wagner-Murray-Dingell Bill at a meeting of the Junior Chamber of Commerce.

Dennison—"Socialized Medicine" was the topic discussed by Dr. J. W. Calhoon, Uhrichsville, at a meeting of the Rotary Club.

Gallipolis—Dr. Ella G. Lupton was in Philadelphia recently celebrating the fiftieth anniversary of her graduation from Woman's Medical College.

News Notes

Chardon—A host of reasons why liberty-loving Americans should oppose the Wagner-Murray-Dingell Bill were forcefully presented by Dr. Lucy Stone Hertzog at a meeting of the local Chamber of Commerce. It was voted to prepare a protest against the bill to be sent to members of the Congress.

Cleveland—New staff officers of Fairview Hospital include: Dr. Ralph J. Frackelton, president, and Dr. R. S. Maurer, vice-president.

Columbus—"Penicillin, a Potent Chemotherapeutic Agent", was the topic discussed by Dr. William G. Myers of the Ohio State University Research Foundation at a meeting of the University Chapter of Sigma Xi.

Columbus—Dr. Jonathan Forman spoke on the Wagner-Murray-Dingell bill at a meeting of the Eleventh Ward Republican Club.

Findlay—Progress in medicine was outlined by Dr. O. P. Klotz at a meeting of the Up-To-Date Club.

Kenton—Dr. W. N. Mundy, one of the oldest and most active members of the Hardin County Chapter of the American Red Cross, was recently elected second vice-president of the unit.

Mansfield—How the passage of the Wagner-Murray-Dingell bill would affect the public was explained by Dr. Charles R. Keller, at a meeting of the local Kiwanis Club.

New **Philadelphia**—New staff officers of Union Hospital are: Dr.E. C. Davis, president; Dr. R. J. Foster, vice-president; Dr. C. A. Bennett, secretary-treasurer, and Drs. Burrell Russell, C. J. Miller and H. E. Reed, members of the executive committee.

Oberlin—Dr. Lorin E. Kerr, Lorain County health commissioner since August, 1941, has been appointed a Surgeon (Major) in the Reserve Corps of the U. S. Public Health Service. His assignment is regional director for the Farm Security Administration Medical Care Program in the following states: Washington, Oregon, Idaho, Utah, Montana, Wyoming and Colorado.

Troy—"Health and War" was the topic discussed by Dr. Harry Wain, Troy and Miami County health commissioner, at a meeting of the Kyle Parent-Teachers Association.

Warren—New staff officers of the St. Joseph's Hospital are: Dr. L. A. Blum, Niles, president; Dr. J. A. Heeley, Warren, vice-president; Dr. M. J. Crow, Warren, secretary.

Xenia—Branding the Wagner Bill as a menace, but stressing the need of a plan for medical insurance sponsored by the medical profession, Dr. Reyburn R. McClellan addressed the local Business and Professional Women's Club.



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Do You Know - - -

Dr. A. L. Van Horn, formerly of Columbus, has been appointed acting chief of the division of health services of the U. S. Children's Bureau, Washington, D. C. His new duties include supervision of the emergency maternity and infant care program for the wives and children of enlisted men in the armed services. Dr. Van Horn has been assistant director for Crippled Children in the Children's Bureau for several years. He was previously chief of the Bureau of Child Hygiene of the Ohio Department of Health.

* * *

John E. Farrell, Executive Secretary of the Rhode Island State Medical Society, Providence, explained "The Rhode Island Cash Sickness Compensation Program", at the Eighth Annual Conference of Trade Association Executives, June 20, at the College of Commerce and Administration, Ohio State University, Columbus.

* * *

New directors of the Cleveland Academy of Medicine elected by the membership in the ballot announced at the annual meeting, May 19, are: Dr. A. B. Bruner, Dr. John F. Corrigan, Dr. William A. Sommerfield, Dr. David Steel, Dr. Ralph M. Watkins.

* * *

Dr. John Edwin Brown, for many years one of Columbus' leading eye, ear, nose and throat specialists, ended a 56-year period of practice recently when he announced his retirement. He observed his 80th birthday on May 30.

* * *

While there were only 789 cases of smallpox reported in the entire United States last year, a new low record and a 12 per cent decline from 1942, Ohio reported 118 cases, nearly four times the number reported in 1942, according to the May issue of the *Statistical Bulletin* of the Metropolitan Life Insurance Company.

* * *

For his long and faithful service to the cause of organized medicine, Dr. Geo. Edw. Follansbee, a past-president of the Ohio State Medical Association and the Cleveland Academy of Medicine, was recently presented with the Academy's distinquished citation for 1944.

* * *

New findings in the investigations of the physiological effects of high altitude flight being carried on at the University of Cincinnati College of Medicine under the auspices of the National Research Council were reported by Dr. Marion A. Blankenhorn and Dr. Joseph P. Webb at recent meetings of the Association of American Physicians and the American Society for Clinical Investigation at Atlantic City.

Members of the medical profession are invited to attend the Ninth Annual Assembly of the International College of Surgeons, to be held October 3-5 at the Benjamin Franklin Hotel, Philadelphia. The program will be devoted to War, Rehabilitation and Civilian Surgery. Additional information can be obtained by addressing Dr. Moses Behrend, chairman of the Publicity Committee, 1738 Pine St., Philadelphia.

* * *

The Cleveland Health Museum's exhibit "Food for Health" is on display at the Ohio State Museum, Columbus. The exhibit was opened following an address by Dr. Bruno Gebhard, director of the Cleveland Health Museum, in which he pointed out the needs for better diet in America and how they may be satisfied.

* * *

The nation's first "eye bank" for the collection and preservation of healthy human corneas, which surgeons can transplant to other patients with opaque corneas, restoring their sight, was founded recently at New York Hospital.

* * *

Dr. Ward D. Coffman, Zanesville, has been reappointed by Governor John W. Bricker as a member of the State Council of Public Health.

* * *

The new president of the American Branch of the International League Against Epilepsy is Dr. Charles D. Aring, Cincinnati, elected at Philadelphia, May 14.

* * *

The Council on Medical Education and Hospitals of the American Medical Association has approved the new courses and curriculum in occupational therapy being given at Ohio State University.

* * *

Professor C. E. A. Winslow, Anna M. R. Lauder Professor of Health at Yale University, has been appointed Editor of the *American Journal of Public Health*, succeeding Harry Stoll Mustard, M.D.

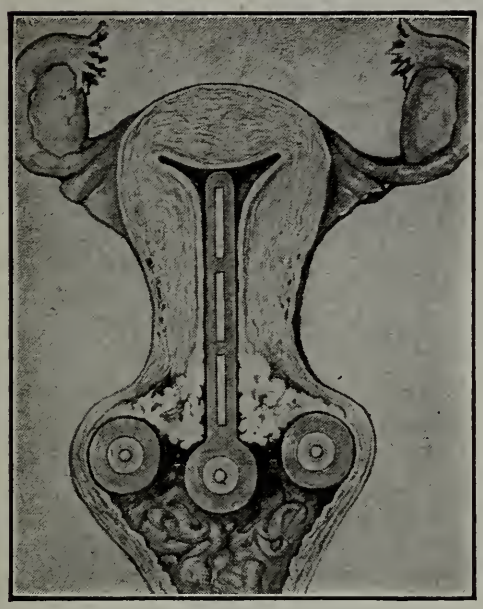
* * *

The average age at death of 3,156 physicians whose obituaries were published in *The Journal of the A.M.A.* during 1943, was 65.2 years.

* * *

Dr. Edwin W. Mitchell, one of Cincinnati's oldest physicians, celebrated his 90th birthday recently. A graduate of Ohio Wesleyan University in 1876 and the Medical College of Ohio in 1882, Dr. Mitchell has been practicing in Cincinnati for 62 years, and is still practicing, though he "takes it a bit easier".

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The Physician's Bookshelf

Education and Health of the Partially-Seeing Child by Winifred Hathaway ($2.50, *Columbia University Press, New York City*) is published for the National Society for the Prevention of Blindness of which Mrs. Hathaway is associate director. The partially-seeing child is a misfit in schools for the blind and is equally a misfit in classes with normally-seeing children. Classes for such children have only been recently organized and are limited pretty much to larger cities. This book should be carefully studied by physicians that each of us may discharge his responsibility for the welfare and education of many thousands of these children who are being deprived of their rightful share in the universal education which our republic is supposed to guarantee.

Safe Convoy: The Expectant Mother's Handbook, ($2.50, *J. B. Lippincott Co., Philadelphia*) by William J. Carrington, M.D., presents cheerful wisdom and guidance for prospective parents. In addition to instruction, the author has followed a modern mode and added entertainment. His diverting anecdotes and historical tales about pregnancy and the superstitions that have gathered about it make interesting reading. In some strange way he makes out of this age-old adventure for husband and wife a triumphant family unit.

The Arthropathies. A Handbook of Roentgen Diagnosis, by Colonel Alfred A. deLorimier, M.D., ($5.50, *Year Book Publishers, Inc., Chicago)* is gathered together and illustrated the worth-while facts about the X-ray diagnosis of joint disease. The book is aimed at all times toward use. The presentation is uniform throughout for the individual features of every joint disease in the same sequence with conspicuous headings so that particular aspects of the different diseases can be easily compared.

Manual of Comparative Anatomy, by Osmond P. Breland, Ph.D., ($2.00, *McGraw-Hill Book Co., New York)*, written not only to serve as a dissection guide, but to emphasize the comparative importance of the organs and structures that are studied. The lamprey, dog-fish, the perch, nectarus, the turtle, and the cat are presented.

Office Treatment of the Nose, Throat, and Ear, by Abraham R. Hollender, M.D., ($5.00. *Yearbook Publishers, Inc., Chicago)* is presented with the thought that the specialty in recent years has widened the scope of office practice. This volume has been put out to fill a gap. Neither the prescribed college text nor the training in special hospitals stresses the office management of these cases. Hence, there is a real need for a book which deals with this subject and the author has given us a good one.

Pain. Proceedings of the Association for Research in Nervous and Mental Diseases. December 18-19, 1942. Vol. XXIII. ($7.50, *Williams & Wilkins Co., Baltimore, Md.)* presents 37 papers filling 468 pages and is an attempt to bring together all the most recent data and viewpoints. Isn't it strange that we physicians are primarily concerned with pain and yet how little use we make of it, either in establishing diagnoses or in directing the management of the case? In our worship of "more objective data", we have unfortunately passed through the period in which pain as evidence had the place that it deserved. Here is a book to help us get back on the beam.

Bio-Chemistry for Medical Students, by William Beale Thorp, M.D., ($4.50, *Third Edition, Wm. Wood and Company, Baltimore, Md.)* incorporates a considerable amount of new material without increasing the size of the volume. An excellent English manual for those of us who want to make a rapid review of the subject.

Human Constitution in Clinical Medicine, by George Draper, M.D., C. W. Dupertuis, Ph.D., and J. L. Caughey, Jr., M.D., ($4.00, *Paul B. Hoeber, Inc., New York City)* is a discussion for medical students of the fact that there is an essential relationship between each individual person and the disease which at any moment he or she may suffer. Most of us are familiar with some of the techniques the physical anthropologist has used in his investigations of this relationship. Many of us are familiar with some of the work of these authors. This approach to disease is as apt to be misunderstood by the superficial reader as is the work of Mills upon

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Cincinnati—"Chemotherapy in Surgery" was the topic discussed by Dr. William A. Altemeier, assistant professor of surgery, University of Cincinnati College of Medicine, at a meeting of the Lions Club.

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climate and Petersen upon weather. Obviously, man is so complex an organism that his totality can only be approached by a study of its component parts. Such information as may be gathered can then be synthesized more or less satisfactorily into a revealing picture of a finished personality. So the physician of the future will observe the constitution of his patient and then the impact of the environment upon this given constitution. In this way, will be correlated weather, climate, and the man himself and in this synthesis it will not be lost sight of that man's bodily build depends to a large degree upon the metabolic tempo of the maternal ovum at the time of his conception.

Nervousness, Indigestion and Pain, by Walter C. Alvarez, M.D., ($5.00, *Paul B. Hoeber, Inc., New York City)* is a popular amplification of the author's earlier book, "Nervous Indigestion". This was, in turn, based upon his "Mechanics of the Digestive Tract". The book is full of those tricks of diagnosis and treatment which enliven the author's addresses. Its reading will do much to make the patient with nervous indigestion understand his problems.

Physiological Psychology, by Clifford T. Morgan, ($4.00 *McGraw-Hill Book Company, New York)* provides a comprehensive, authoritative, and up-to-date survey of the experimental facts in this field. There is in addition an interesting historical introduction and a most valuable review of the basic facts. The book is organized according to psychological data and not according to anatomy and physiology. A worth-while book for collateral reading, if the opportunity ever comes again.

Principles and Practice of Industrial Medicine. Edited by Fred J. Wampler, ($6.00, *Williams & Wilkins Co., Baltimore, Md.)* represents the results of the coordinated effort of 32 experts in this new field. The book is aimed at both the needs of the physician and the medical student. Because industrial medicine is primarily a matter of viewpoint, it is new discipline. In short, it becomes the practice of adult health in which we physicians have had, up to now, little reason to be interested. It is the appearance of books of this kind that show future trends in medical practice much more accurately than does proposed social legislation devised by politicians who have had their hour in the palace.

Vegetable Fats and Oils, Their Chemistry, Production, and Utilization for Edible, Medical, and Technical Purposes, by George Jamieson, Ph.D., ($6.75, Second Edition, Reinhold Publishing *Co., New York City)* is one of the monographs of the American Chemical Society by the distinguished authority on the subject from the U. S. Department of Agriculture. The book is a comprehensive and valuable volume of reference.

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Vol. 40 August, 1944 No. 8

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.* GEORGE H. SAVILLE, *News Editor*

An Outbreak of Typhoid Fever Attributed to Baked Beans Contaminated by a Chronic Typhoid Carrier

EARL E. KLEINSCHMIDT, M.D.*

THE OUTBREAK of typhoid fever under consideration is significant in several respects: (1) It established a new route of spread for typhoid fever; (2) it calls attention to the need for more careful health supervision during wartime of wholesale food establishments, and especially those which are engaged in dispensing prepared foods in large quantities to the public; (3) it emphasises the necessity for continued effort to control typhoid carriers in our larger cities; and (4) it illustrates the explosive potentialities of outbreaks of this disease despite a downward trend in its incidence and a condition of apparent safety as might be inferred from current statistical observations.

Like other large cities in Ohio, Toledo had been experiencing a gradual decline in the incidence of typhoid fever over the past decade. The number of cases reported had receded from a high of 21 cases in 1933 to 1 case in 1942 (Table I).

TABLE I

Incidence of Typhoid Fever. Toledo, Ohio: 1933-1942

Year	Number of Cases
1933	21
1934	21
1935	14
1936	12
1937	17
1938	7
1939	9
1940	8
1941	3
1942	1

*Jointly with Jean B. Koupal, M.D., M.S.P.H.; Fred Wiggers, B.S., (died Nov. 29, 1943); and Herbert C. Colwell, M.S.P.H., statistician, Department of Health, Toledo, Ohio. The charts and graphs used in this article were prepared with the technical assistance of Mr. Colwell..

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The Author

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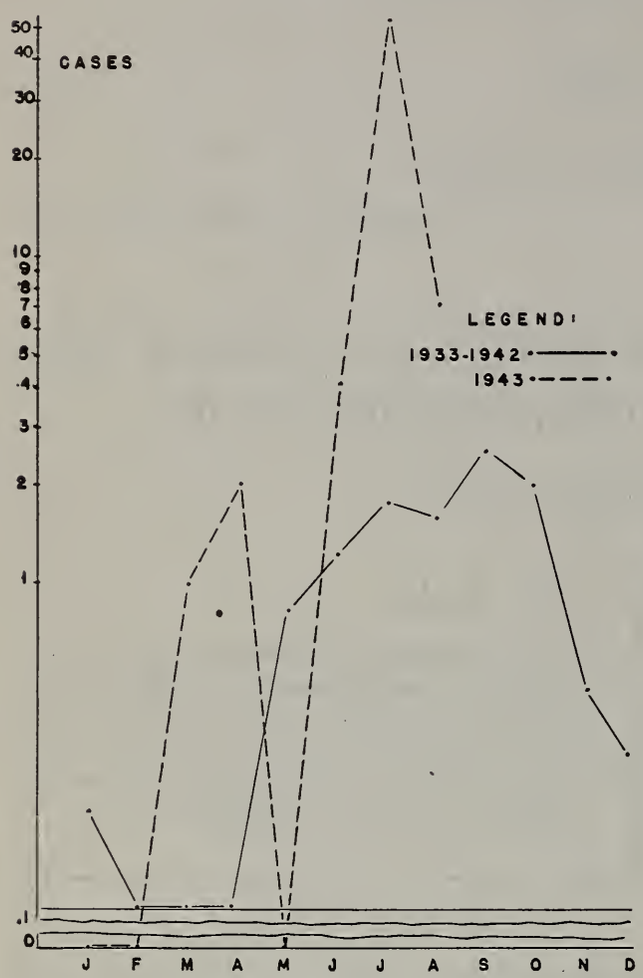
Such cases as did arise were usually "vacation" typhoid, attributed usually to drinking contaminated water at neighboring Summer resorts. Those carriers which had already been discovered as the result of previous investigations were kept under careful surveillance. Studies of seasonal trends of resident cases of typhoid fever revealed that the highest incidence of the disease took place in September of each year. A mean of 2.6 cases had occurred in this month over the past 10 years (Chart I). In short, the situation in Toledo was comparable in every respect with conditions elsewhere in Ohio.

The first indication that something unusual was happening was a summary report by the Bureau of Communicable Diseases to the effect that 12 cases of "suspicious" typhoid fever and possible food poisoning had occurred in the city from March to July 3rd.

Practicing physicians were apparently unaware as to what was taking place, since the health department heard ouly that persons with fever of undetermined origin were being hospitalized in private hospitals, some of which "looked like typhoid fever". Tentative diagnoses of intestinal influenza, colitis, undulant fever, food poisoning,

chronic appendicitis, and pelvic abscess were being made in an effort to explain the clinical manifestations. A small number of physicians insisted, however, that the disease in question was typhoid fever. As clinical diagnoses were later confirmed

CHART I



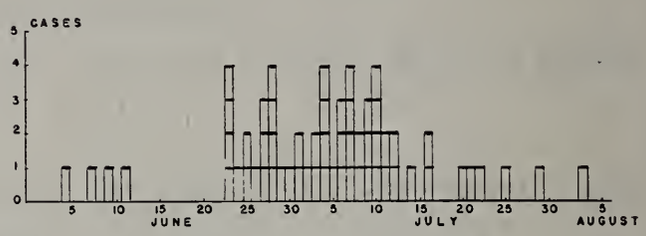
SEASONAL TREND IN RESIDENT TYPHOID FEVER CASES, 1933-1942 AND 1943; TOLEDO, OHIO

by laboratory tests, it became evident that we were dealing with a typhoid fever outbreak of undetermined origin (Chart II).

EPIDEMIOLOGICAL INVESTIGATION

Epidemiological investigations by the health department staff resolved themselves into the following routine measures: (1) Careful histories were taken on each patient and all family contacts by field nurses especially drilled in this procedure. Forms especially prepared for this purpose were filled out and returned daily to the health department where they were carefully studied for evidence of a common denominator. (2) All suspected and proven cases isolated in private hospitals were interrogated for evidence as to the possible source of the infection. This procedure alone netted many additional "hidden" cases which until then were being treated on a symptomatic basis only. (3) A register of all known cases of typhoid including convalescent and chronic carriers in the city was established; in addition, appeals were addressed to the public through the press and radio to report any suspicious cases to the health department which might in any way resemble typhoid fever. (4) As soon as the cases histories were obtained laboratory studies were made of water supplies, milk, ice cream, meat, fish, fruit, and vegetables reported as consumed by patients. Regular examinations were also made of the indoor pools in

CHART II



FREQUENCY OF TYPHOID FEVER CASES BY DATE OF ONSET, JUNE 4 TO AUGUST 4, 1943, TOLEDO, OHIO

the city to ascertain whether or not they were a possible source of the infection.

The cooperation of each practicing physician and hospital superintendent was requested by the public health committee of the local academy of medicine with respect to: (1) Prompt reporting of all cases of suspected or proven typhoid fever to the health department; (2) requesting blood culture and Widals of their patients early in the course of the disease and repeated Widals and stool cultures if the disease had progressed undiagnosed into the second week: (3) directing laboratories to report all positive confirmatory findings of typhoid to the health department as well as to the private physician; (4) soliciting cooperation of physicians with respect to precautions to be taken by patients during convalescent period; and (5) immunization of all family contacts.

As the epidemiologic reports began to come in and spot maps were followed, it became evident that the distribution of cases was spotty, and followed no especial pattern as would be the case with water or milk-borne outbreaks. Repeated examinations made of samples of city water in the affected sections of the city later confirmed this suspicion. The same later proved to be true as regards the possibility that milk might be responsible for the outbreak.

With water and milk definitely ruled out as vehicles for the spread of the disease, interest centered on the possibility that prepared lunches, dairy products, raw fruits and vegetables, seafoods, and meats were possible sources, but in vain. A total of 125 restaurants, 17 beer-taverns, 45 confectionery shops, 82 groceries, 68 fruit and vegetable markets, 17 meat markets, 15 fish markets, and 7 drug stores were checked. Careful histories were taken and stool and urine

CHART III

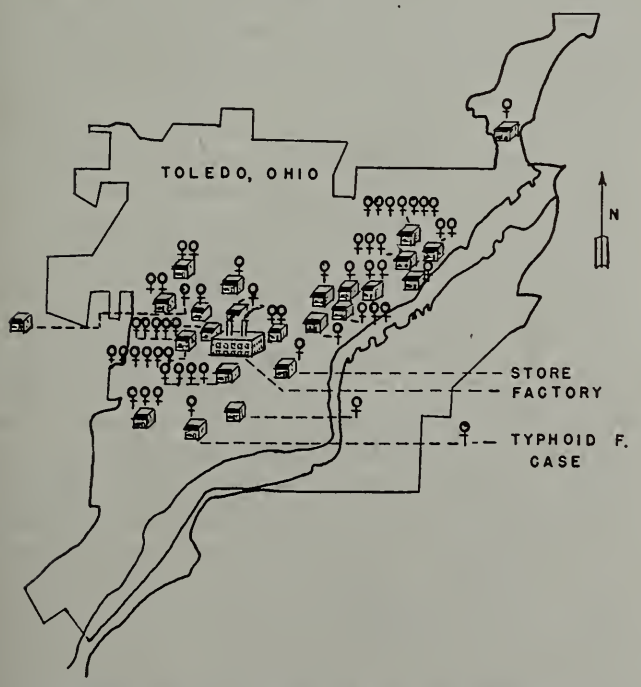


CASES AND DEATHS OF CONFIRMED TYPHOID FEVER BY CENSUS TRACTS; JUNE 4 TO AUGUST 3, 1943. TOLEDO, OHIO

specimens were procured from clerks and food-handlers whenever three or more cases could be traced to any individual food establishment.

As the investigation continued, however, several things became noticeable from studies of spot maps: (1) Absence of cases in West Toledo; (2) only two cases occurred on the entire East Side (Chart III); (3) heaviest concentration of cases occurred in the old North End; (4) cases appeared to cluster about six food establishments (Chart IV); (5) more women than men affected (Table II); (6) number of victims working in food stores showed a decided increase; and (7) victims lived in old style homes having poor plumbing, and few had electric refrigeration.

CHART IV



DISTRIBUTION OF BEANS FROM WHICH TYPHOID FEVER DEVELOPED, JUNE 4 TO AUGUST 3, 1943. TOLEDO, OHIO

TABLE II

Attack Rates of Confirmed Typhoid Fever Cases by Age and Sex; June 4 to August 3, 1943. Toledo, Ohio

Age Group	Rate per 100,000 Population[1]		
	Total	Male	Female
All Ages	21.7	15.5	27.0
Under 5 years	26.3	39.5	11.2
5- 9 "	25.9	9.9	43.5
10-14 "	30.6	26.9	34.2
15-19 "	30.1	9.8	46.0
20-24 "	56.1	0.0	72.5
25-29 "	30.7	29.4	31.4
30-34 "	0.0	0.0	0.0
35-39 "	22.9	9.6	35.0
40-44 "	23.7	28.0	19.3
45-49 "	32.1	21.7	42.2
50-54 "	16.6	21.7	11.2
55-59 "	6.0	11.6	0.0
60 and over	0.0	0.0	0.0

[1]Based on 1943 estimated population of 297,000 less an estimated 20,000 males in the armed forces of the United States.

TABLE III

Occupations of Confirmed Typhoid Fever Cases; June 4 to August 3, 1943. Toledo, O.

Occupation	Number
Professional Workers	0
Farmers	0
Owners or Managers	1
Food-Handlers	8
Non-Food-Handling Clerks	3
Protective Service Workers	1
Skilled Defense Workers	14
School and Pre-School Children	19
House-Wives	13
Laborers	1
Total	60

Of the group of 60 victims of the outbreak in Toledo 19 were children of pre-school and school age; 14 were defense workers in war plants; 13 were housewives; 12 were persons engaged as clerks or food-handlers in grocery stores and delicatessen shops; and 2 were engaged in business (Table III).

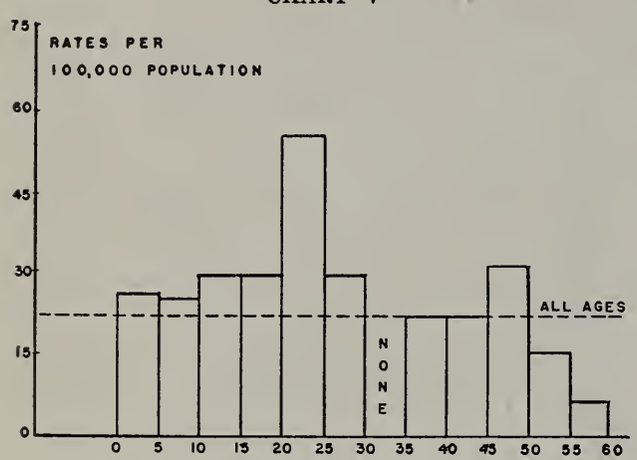
From the standpoint of racial involvement 59 were of the Caucasian or white race, and 1 was a Negro. Nothing especial was noted with respect to age, sex, or economic status of those persons afflicted with the disease. Of considerable interest was the finding that the greatest incidence of the disease took place in the adolescent and early adult age groups (Chart V).

Early in August, while tabulating the foods eaten by the victims, it was noticed by one member of the staff that three patients had indicated that they had eaten baked beans. Further questioning revealed that all three persons had pur-

chased them from the same firm, which, oddly enough, carried as its slogan, the tempting phrase: "Clean, Pure and Delicious Food Products". But, as later investigation revealed, this salubrious caption proved to be very misleading.

The nursing staff visited each patient and secured a list of all foods eaten and the source. Suffice it to say, baked beans prepared by the Blank Food Products Company were mentioned 34 times. Further investigation revealed that a total of 49 patients had eaten these beans within an average of two weeks prior to the onset of

CHART V



TYPHOID FEVER ATTACK RATES FOR TOTAL POPULATION BY AGE GROUPS; JUNE 4 TO AUGUST 3, 1943. TOLEDO, OHIO

their illness, and 5 others had procured delicatessen foods from the same stores which also sold these beans.

Rather interesting was the manner in which many of the cases were found and correlated with one another. One instance should suffice to illustrate this phase of the investigation.

While under the impression that all cases were not being reported to the health department, a field epidemiologist set about early in July to visit all cases held under suspicion in the local hospitals. Approximately a dozen cases were discovered in this manner.

One of these persons, a young woman, H. K., admitted that she had felt badly for the previous week, but had, nevertheless, continued to wait on trade in the grocery store where she worked. Upon examination it was evident that she had typhoid fever, and that she was well along in the fastigial period of the disease. Classic signs of typhoid fever such as rose spots, enlarged spleen, diarrhea, and toxemia were already present.

An investigation of the store in which she worked revealed it to be in a deplorable sanitary condition. The equipment was old-fashioned, and of a type difficult to cleanse. The only toilet facilities were on the second floor, and strikingly enough, there was no provision for hand-washing facilities near the toilet. Hand-washing could only be performed in the rear of the store where dishes and utensils were likewise washed. This person, nevertheless, dispensed milk, ice-cream, sliced meats, and served delicatessen products—including baked beans—to her customers. Six cases were directly traceable to her store. Considering the volume of her trade, it is nothing short of remarkable that many other persons did not fall victims to the disease, especially so in view of the fact that she must have handled many foods during the time she apparently was in the prodromal and early fastigial stages of the disease. She eventually died of the disease.

IDENTIFICATION OF THE PRIMARY CASE

With the disclosure that at least 49 patients had eaten baked beans prepared and packaged by the Blank Food Products Company, the investigation shifted to the personnel and sanitary conditions of this firm. All food-handlers were required to submit stool and urine specimens. One of these, I. H., disclosed to the investigator that she had had typhoid fever 20 years previously. She also stated that she had been engaged in her present occupation since May 31. Her stools were found positive for E. Typhosa organisms on repeated examinations. A Widal examination was also positive. Following repeated observations of her activities, it became evident to the staff that this person was the source of the outbreak.

Her part in the process of preparing beans for market consisted in placing a slip of paper on the beans in each casserole after she had weighed it. Occasionally, the tips of her fingers touched the surface of the beans. When not busy at this especial task, she also was observed filling paper cartons with beans as well, using a short-handled scoop for this purpose. Since the subject of sanitation and cleanliness was seldom mentioned to her, or to any other of the employees of this firm, it was quite evident that any indiscretion with respect to their toilet habits could easily account for the contamination of the beans and other food products prepared by them. Moreover, since the beans were already baked by the time they reached this worker, any organisms innoculated into the beans by her were not destroyed, unless perchance they were thoroughly heated again before being eaten by the consumer. As was proven in our laboratory, warm moist baked beans proved a culture medium quite suitable for the continued growth of typhoid organisms.

The building in which the beans were prepared was of especial interest from a sanitary standpoint. All operations concerned with the preparation, baking, weighing, mixing of ingredients, and packaging were carried out in a single large room. Flies were found everywhere—some in the beans. The toilet door hung ajar; and hand-

washing facilities were indescribable. The workers, themselves, while neat in their outward appearance, showed very little evidence of ever having any instructions in habits of personal cleanliness. They wore no caps, and their fingernails were obviously dirty. On several occasions representatives of the health department had warned the proprietor of these aforementioned conditions, but to no avail.

Just why everyone who ate beans from this establishment did not acquire the infection is problematical. The theory has been advanced that the contamination was spotty, hence accounting only for occasional infections; moreover, since most people invariably heat them again before eating, it is quite conceivable in other instances that the organisms were destroyed. As Beard[1] points out, the survival time of E. Typhosa is dependent on the moisture content of the medium in which they are suspended. In our studies the organisms survived for a period of 5 days in baked beans kept at room temperature, and were apparently destroyed at ice-box temperature in 48 hours.

Needless to say, with the closure of this food establishment, the outbreak terminated as dramatically as it had begun.

EXTENT OF OUTBREAK

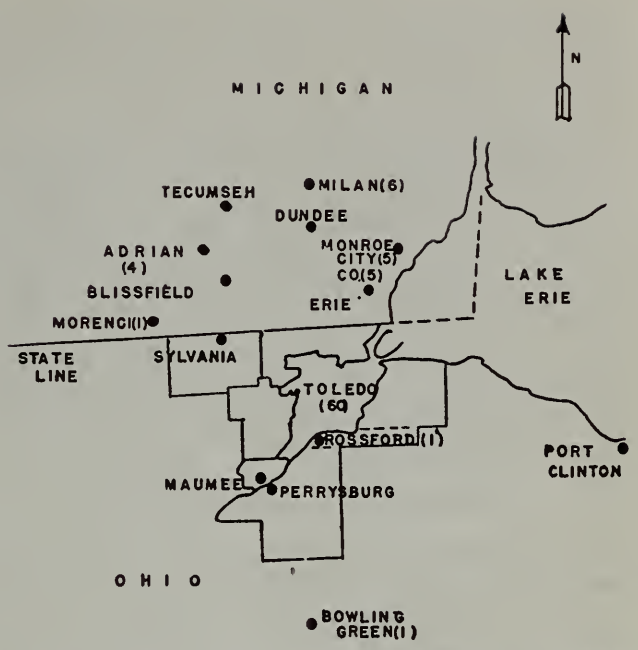
As soon as it became evident that the Blank Food Products Company was largely responsible for the outbreak a check was made of all stores and food establishments supplied by this firm (Chart VI). Not only did this firm supply the

CHART VI



AREA AND NUMBER OF STORES SERVED BY TOLEDO BEAN DISTRIBUTOR DURING TYPHOID OUTBREAK; TOLEDO, OHIO, 1943

CHART VII



NUMBER OF TYPHOID FEVER CASES IN OUTBREAK IN AREA, JUNE TO AUGUST, 1943. TOLEDO, OHIO

stores named by the victims of the outbreak in Toledo, but also delivered its products to neighboring towns including Maumee, Perrysburg, Bowling Green, Port Clinton, and Rossford in Ohio. In addition, it supplied stores in Blissfield, Adrian, Morenci, Erie, Monroe, Milan, and Dundee in Michigan. Since there were small outbreaks of the disease in several of these towns at the same time the Toledo outbreak occurred, some of which have definitely been traced to the eating of baked beans, it was assumed, at least, that the primary case in Toledo, I. H., was undoubtedly responsible for the majority of the cases elsewhere (Chart VII).

Since June 1, 79 cases of typhoid fever were reported to the Toledo Health Department from citizens of Toledo proper. Of this number, 19 were later reclassified as due to food poisoning, or to **Salmonella Schottmuelleri** (type B). The balance of 60 cases were proved to be typhoid fever by clinical and laboratory studies. Two of these were infected by different carriers. Two others undoubtedly acquired their infection from drinking contaminated water from outside the city. Of the remaining 56 cases, 49 were found to have consumed beans from the Blank Food Products Company between June 1 and July 25. Five others were close contacts of these 49 patients dealing at the same stores which sold the baked beans. In short, 54 out of a total of 60 proven cases in Toledo, or 90 per cent were definitely traced to one common denominator—baked beans.

Of the 5 cases which occurred in Lenawee County, 23 cases in Monroe and Washtenaw counties in Michigan, 4 of those living in the

city of Adrian in Lenawee County disclosed to representatives[2] of the Michigan Department of Health that they ate baked beans procured from stores supplied by the Blank Food Products Company of Toledo.

The health officer of Monroe County, Michigan, Doctor Albert Heustis, was able to explain the source of the outbreak of 13 cases in his jurisdiction on the basis of epidemiological and laboratory findings. Interestingly enough, the Blank Food Products Company of Toledo supplied a total of 13 stores in Milan and Monroe. This finding served to advantage in correlating the Michigan outbreak with that of Toledo and its immediate environs.

CARRIERS DISCOVERED IN TOLEDO

Besides the carrier, I. H., discovered in the Blank Food Products Company, a total of three others were brought to light during the course of the investigation. One, E. A., was a cook in a restaurant for many years, repeated stool cultures and Widals proved her to be a chronic carrier. One case was definitely attributed to her. Extensive questioning revealed that she had had the disease 30 years previously. Another carrier was related to a proven case; and the fourth could not be proved to be responsible for any of the cases reported in this outbreak.

One carrier was discovered by Doctor Albert Heustis, Health Officer of Monroe County, but, in his opinion it is highly unlikely that she was responsible for the outbreak in and around the city of Monroe.

CONTROL OF OUTBREAK

Control measures consisted primarily of the following routine activities: (1) Blank Food Products Company ordered closed; (2) isolation of all patients together with instruction of patients and contacts as well with respect to personal hygiene; (3) immunization of a total of approximately 1,254 contacts with the three dose triple vaccine was carried out by the health department. Approximately another 1,000 immunizations were performed by the practicing physicians in and about Toledo; (4) sanitizing of 125 food establishments involved in the outbreak; (5) public appeal via the radio and press for cooperation and early reporting of cases; (6) special instructions to practicing physicians and laboratory directors in private hospitals; (7) issuance of printed instructions to all convalescent cases with respect to the necessity for continued observation by the health department; and (8) signing of contracts with all carriers.

While one would logically expect to find that about 3 per cent of convalescent cases become chronic carriers[3] thus far, at least, laboratory studies fail to disclose any carriers in the Toledo group of patients who have apparently recovered from the disease.

THE CASE FATALITY RATE

There were 6 deaths out of a total of 60 proven cases in Toledo, or 10 per cent, of which there was no question that the primary cause of death was typhoid. The two additional deaths from emboli must likewise be classed as typhoid deaths because the emboli probably would not have occurred had the patients not been debilitated from typhoid. There were no deaths in Michigan. The case fatality rate from this outbreak is, therefore 9.8 per cent.

Four of these cases upon admission to the hospital were already in the third week of typhoid fever. Of the 8 deaths, four occurred within a week of hospitalization; two died after protracted illness; and two passed away after all symptoms ascribed to their typhoid fever had subsided. One of the latter group fell dead of a pulmonary embolus on the day she was scheduled to leave the hospital; the other collapsed with a coronary embolus two hours after she arrived at her home.

LABORATORY STUDIES

Routine methods were employed in examinations made of serum, feces, and urine specimens submitted to the laboratory. Widals were performed using the rapid slide agglutination method. In such instances where the sera reacted weakly, use was made of the time-honored agglutination method advocated by the Standard Methods Committee on Diagnostic Procedures and Reagents of the American Public Health Association. In the case of feces examinations, direct plating was made to Eosin-Methylene-Blue agar and Salmonella Shigella (Difco) agar; next, a transfer was made to enrichment broth with incubation overnight. Plating was again carried out to Eosin-Methylene-Blue, S –S agar, and McConkey's agar with overnight incubation. Suspicious colonies were next tranferred to Russel's double-sugar medium. If the results indicated E. Typhosa, these growths of organisms were added to antiserum for agglutination; at the same time a transfer from the same culture was made to a series of carbohydrate media to ascertain if the growth was characteristic of **Eberthella Typhosa.**

Cultures were made from all cases occurring in Toledo and in lower Michigan for the purpose of ascertaining the various strains of **Eberthella Typhosa** involved in the outbreak. Craigie of the University of Toronto, it will be recalled, devised a method (4) whereby it is now possible to differentiate approximately 13 bacteriophage types of the organism. Using special strains of bacteriophage, this worker has provided the epidemiologist with a new technic for correlating his findings. It is indeed a valuable adjunct to regular epidemiological studies.

In the case of the outbreak under consideration, it served to advantage in correlating the epidemiological findings. Studies[5] made in the New York State Department of Health Laboratories revealed that all cases traceable to the carrier, I.H., located in the Blank Food Products Company belonged to bacteriophage type "A". The other carriers discovered in the course of the investigation belonged to bacteriophage type "C".

Some idea of the volume of work performed by the laboratory in this outbreak may be gained from the following information: A total of 796 stool examinations were performed in the Toledo and State Health Department laboratories, 38 of which were found to be positive. Widal tests numbered 109 of which 52 were postive. Beside these examinations, a large number were made in the laboratories of private hospitals.

SUMMARY

An explosive outbreak of typhoid fever resulting in 60 known cases in Toledo, Ohio, and 21 others in three counties in Southern Michigan occurring in the months of June and July, 1943, is described.

Epidemiological investigation revealed the outbreak to be due in the main to the eating of baked beans contaminated by a single chronic typhoid carrier living in Toledo.

A resumé of the technic employed in finding the primary case is given as well as control measures instituted.

This outbreak serves to illustrate the potential danger to the public in war-time of food-handlers whose status with respect to typhoid fever is unknown.

ACKNOWLEDGMENT

We acknowledge with appreciation the excellent cooperation in the field by Dr. F. S. Leeder, Director of the Division of Enteric Diseases of the Bureau of Epidemiology of the Michigan Department of Health; also, the help given by Dr. Albert Heustis, Health Director of Monroe County, Michigan. Appreciation is also due Dr. Roll H. Markwith, State Health Commissioner of Ohio, for his valuable help, and the assistance provided the Department by the members of his staff; to Dr. Bruce Douglas, Health Commissioner of Detroit, and Miss Laura Peck for their kindly help, and to Dr. Marion B. Coleman, of the New York State Health Department, who performed the typing of the various strains of typhoid bacilli.

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Psychoses Following Prostatic Surgery

Four cases of psychosis occurred in elderly men who had evidence of prostatism and who, according to recognized standards, would all be classed as good surgical risks. However, their mental states following preparatory or operative procedures were more disastrous than if they had been prostatectomy deaths. Many others, burdened with poor renal function, infection, hypertension and other complicating conditions make complete recoveries.

Those of us who have practiced urology for several decades well remember the bitterness the annual suprapubic versus perineal prostatectomy low mortality discussions create. It was alleged that most of the deaths followed the first-stage cystotomy, and these were not counted by the suprapubic advocates, while they, in turn, stated that the deaths from "urethral fever" due to the indwelling catheter passing through the posterior urethra should be classified as operative deaths. The literature records a series of many hundreds of successful prostatectomies with no deaths. However, those are only operative statistics. What we are primarily interested in is how best to take care of the next hundred cases of "run of the mill" prostatism that come to our offices.

Rather than a low prostatectomy death rate, the general public is interested in a low prostatism death rate. Hence, the minute a man is examined he should be placed on our mortality list. If his death is due to a psychosis following catheterization for an acute retention, it is still a prostatism death. These psychoses in the elderly male, if they had not been preceded by a surgical episode, would ordinarily be classed as diffuse, senile dementias.

Much has been written on the diagnosis and treatment of the senile dementias. The psychiatrists and geriatricians point out that all these changes of character have a gradual insidious development, and many may be arrested by proper treatment before terminal changes occur. The most illuminating statement I could find in the literature was by Hugh H. Young (Practice of Urology, Vol. 1 p. 480): "Psychoses furnish a very perplexing problem in prostatic cases. The mental picture is occasionally very difficult to explain and the etiology impossible to interpret. The psychosis may be due to impaired renal function, chronic infection, and occasionally low grade septicemia. In some instances, however, chronic psychosis with marked disorientation persists, with little or no evident cause," and that is of little help.—Arno G. Folte, M.D., San Francisco, Calif. and Western Med. Vol. 60, No. 6, June, 1944.

Benign Pulmonary Changes in Arc-Welders: Arc-Welder's Siderosis

J. A. GROH, M. D.

PULMONARY changes as demonstrated on X-ray films of the chests of some arc-welders have been observed since 1936 by various authors. First described by Doig and McLaughlin[1] in England, Enzer and Sander[2] of Milwaukee had the opportunity to follow some of these cases over a period of years and autopsied one case. It was stated that these changes would occur only if the welding operation was done in confined places, poorly aerated, much as the insides of tanks. Reports were few and not always confirmative.

Several arc-welders found unfit for military duty at the Army Induction Station in Cleveland, Ohio, on the basis of certain pulmonary changes observed on their chest films, called my attention to the possibility of a common lesion in their lungs. A connection to arc-welding was discounted by the plant authorities where all of these men were employed. This industrial plant employed about 125 arc-welders, almost all in the younger age groups, below the age of 40 years. These men had spent most of their working years in welding, and many had been taught welding in the welding school maintained by this firm.

The welding operations were on truck and jeep frames and gun mountings in jigs of two or more men in a large factory building, about 900 feet long, 100 or more feet wide, and about 40 feet high. A simple canvas curtain separated these operations about 15 feet apart, protecting each jig from exposure to ultra-violet radiations. Overhanging each operation was a large cone-shaped hood with a suction fan in the tip of the cone. In so disposing of the welding fumes, they were brought past the breathing zone of the welder. It has been assumed that this protection was adequate.

Out of the 125 welders, 83 men of the younger group presented themselves for X-ray studies of their chests. Complete histories were taken as to previous exposure to silica dusts. Any cases with positive histories were excluded. Seventy-one per cent of 83 chests showed a peculiar fine nodulation evenly distributed over the lung fields. In some of the cases it seemed to be more granular and denser, individual lesions sharply defined, overlapping in the thicker central lung fields about the hilus regions. These lesions measured from 1 to 3 mm. in diameter and were roughly rounded. Linear markings in the vicinity of the hili were found to be exaggerated in a few cases, but not any more frequently than seen in a group of normal chests. The hilus regions were not enlarged nor prominent, and no large nodes could be identified along the mediastinum.

One is impressed by the absence of fibrosis, pericardial or diaphragmatic adhesions, and thickened septa. There were no inflammatory changes whatsoever and no thickened pleura. These lungs were perfectly normal except for one thing—the nodulations. Therein lies the difference between the arc-welder's lung and a simple, uncomplicated silicosis, which is its closest imitator. Tuberculosis of a miliary type can be ruled out only on the clinical history, as the patient would be ill, almost toxic, and the arc-welders have no complaints whatsoever in reference to an acute illness. The differentiation on the X-ray film alone would be difficult.

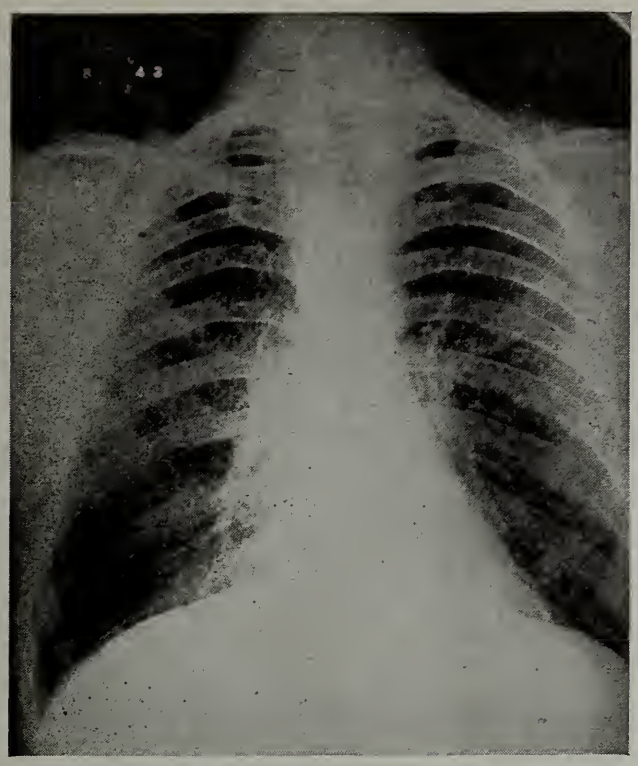
We classified positive cases in two groups—a minimal and an extensive group. This was based primarily on the extent of involvement of the lungs. The minimal group showed a softer mottling about the central lung fields, and the extensive group included a more wide-spread, denser mottling including apex and bases. None but distinctly mottled lungs were classified as positive cases, and all lungs with increased linear markings only were grouped with the normal, although some of these cases were thought by others to be early positive cases. This simple classification placed 33 cases of the 59 positive into the extensive group.

According to these findings we have a higher incidence than ever before observed in any group study. Still, the welding operations were not carried out in closely confined places, such as inside tanks or poorly aerated small rooms, which

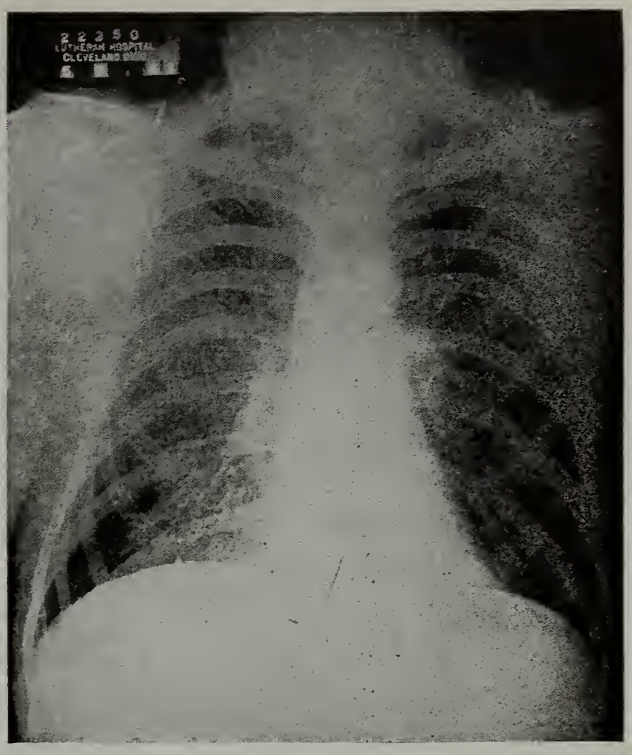
The Author.

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Example Case 1. J.P., 22346; age 35. Six years of steady arc-welding. Classification: Extensive (no known silica exposure).



Example Case 2. J.A., 22350; age 39. Twelve years of steady arc-welding. Classification: Extensive (no known silica exposure).

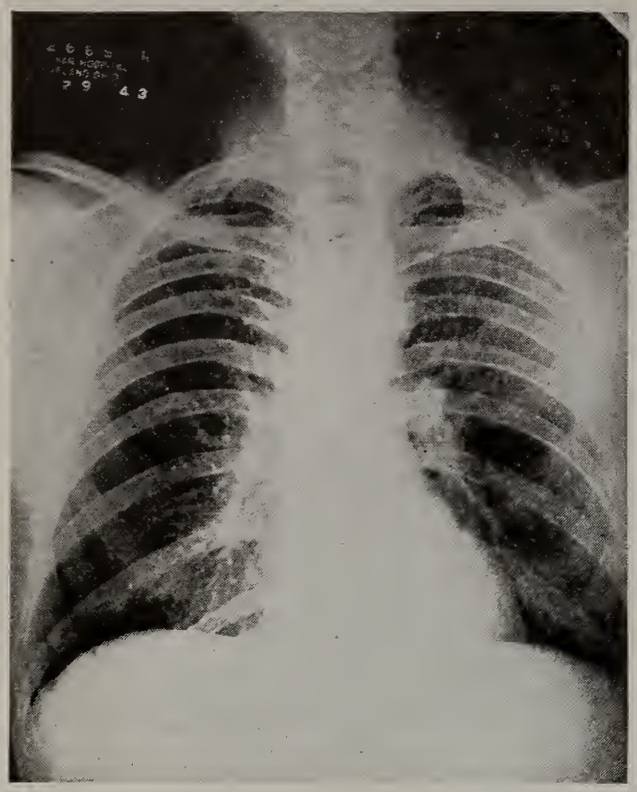
was formerly held to be the sole explanation. This proves that the necessity for adequate ventilation exists in other than the small confined space. Six non-welders working along with the welders, such as cleaners, helpers, electricians or crane operators showed normal lungs, indicating that in lower concentrations of the fumes, iron oxide is not deposited in the lung.

In this study we were impressed by the complete absence of active pulmonary tuberculosis. There were five men who showed fibrotic or calcified, adult type lesions, all of whom had been welding between five and 10 years steadily. None showed any reactivation of the old lesions. This finding has been uniformly reported by previous authors, one of whom actually described the healing of an active ulcerative tuberculous lesion in a lung which was the seat of extensive iron-oxide staining, in spite of the fact that the patient had never ceased welding. (Presented in the November meeting of the Industrial Hygiene Foundation, 1943).[4] Hence all the evidence available thus far indicates that the condition of arc-welder's lung does not predispose to pulmonary tuberculosis or reactivate an old arrested tuberculosis of the lungs.

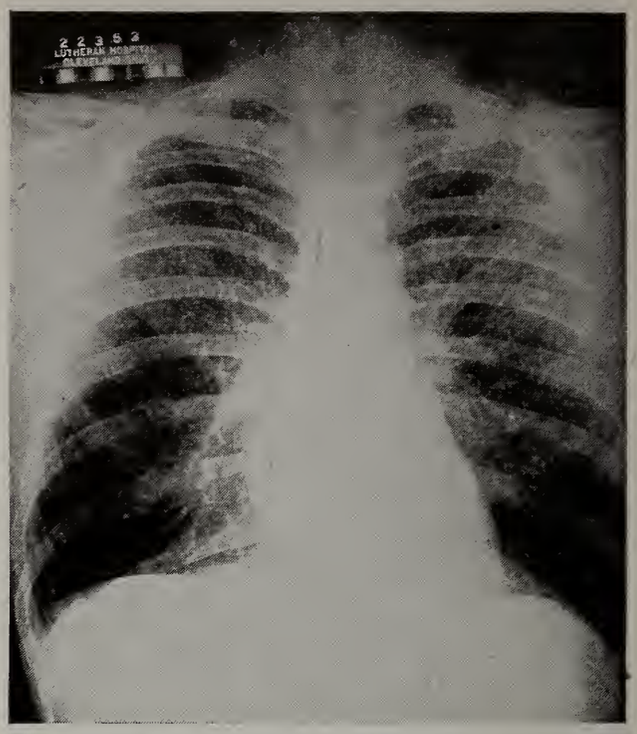
The pathological picture as described by Enzer and Sander in 1938,[2] based on an autopsy finding in one of their 10 cases, shows conclusively that iron oxide is the invader, deposited along the pulmonary vessels into lymphatic channels and also into the regional lymph nodes. This must be recognized as the opaque substance which on the X-ray plate manifests itself as a fine, discrete mottling or nodulation varying in size from 1 to 4 mm. in diameter. "A fine, black pigment was found widely distributed in both lungs with a complete absence of any scarring or fibrous nodulations." "There is an entire absence of fibrosis. Inflamatory response to this foreign material is likewise lacking. Giant cells do not occur. Connective tissue stains disclose that lymph nodes are free of fibrous tissue." "In particular, emphasis should be placed on the absence of phagocytes and fibrous tissue around bronchi and blood vessels at the root of the lungs."

In a few cases we noted a conspicuous absence of correlation between the pulmonary findings and the duration of welding: an observation which Sander described as "disturbing and apparently inconsistent". One of our negative cases had been welding without interruption for 16 years, whereas several of our extensive cases had been employed as welders for only six years. These are exceptions, however, We believe that the importance of the time element is best shown in the averages. The average period of welding for those with normal lungs was 6.7 years, for those with slight nodulation 8.5 years, and for those with more extensive changes 9.2 years.

Our experience does not allow us yet to confirm or deny the conclusion given by Enzer and Sander that conditions of exceptionally poor ventilation, such as inside tank welding operations, explain the positive cases. All of our welders apparently worked under similar conditions throughout. An exhaustive study of the atmos-



Example Case 3. J.P., 22669; age 39. Six years of steady arc-welding. Classification: Extensive (no known silica exposure).



Example Case 4. P.K., 22353; age 33. Six years of steady arc-welding. Classification: Minimal (no known silica exposure).

pheric conditions at the various stations of operation was not done. These might have demonstrated actual differences in exposure which would explain the variation in the development of signs. If we are forced to look elsewhere for an explanation of the occasional case of conspicuous disparity, it seems to us that the most plausible explanation would be a variation in individual susceptibility, depending upon such factors as tendency toward mouth breathing and defects in the physiological mechanism of dust filtration in the upper air passages. Both factors may play a part.

Even though the presence of arc-welder's nodulation apparently causes no disability in the physiological sense, it is nevertheless a rather serious potential menace to the mental stability of the affected workmen, when its presence is revealed by X-ray examination. The evaluation of the findings is not the function of the physician in the induction center. In most cases he does not even have the advantage of an occupational history to help him in diagnosis, and in any case it is not his function to give advice. He refers the man back to his physician for observation. It is for this reason that the general practitioner must know and recognize the arc-welder's lung in order that he may advise his patient intelligently.

What should be the attitude of the physician who is confronted by this condition? How should he interpret the situation to his patient? These are questions which we can not answer at the present time with a complete air of finality. Neither, however, can we ignore them until all the final pathological and clinical results on this subject have been presented and evaluated. We must, therefore, answer these questions in the light of the evidence presented to date, and base our advice on assumptions which seem logical in the light of present knowledge.

Our advice to the arc-welder with these positive X-ray findings is that it is entirely unjustified for him to change his occupation and sacrifice his years of valuable experience in welding. We advise him that there is no evidence which suggests any disability from this exposure nor any evidence which suggests any possible future disability from the condition.

We furthermore attempt to impress him with the idea that an X-ray plate taken in the future, either in a mass survey, in a selective service examination, or a pre-employment examination, may be so interpreted as to cause unjustified apprehension over his physical condition. This warning may prove extremely valuable in protecting him against a state of panic if the X-ray findings are interpreted as something other than arc-welder's siderosis by his future medical examiners. With this advice in mind he may reasonably request further consultation and refer back to his original examination and occupational history to establish the identity of his lung mottling.

In viewing this condition as benign, we believe we are completely justified. If this assumption is not borne out by future research, and the condition does prove to have serious aspects, ex-

perience has shown us that news of pathological seriousness, like other bad news, travels fast. Serious results, if any ever do develop from this condition, would find a spectacular place in current medical literature. We repeat that we can see no reason at this time to anticipate any cause for present alarm from this arc-welder's siderosis. We can see much danger in attaching an unjustifiably serious prognosis to the condition at this time, because once an alarmist outlook has gained an entrance into medical literature, it will be perpetuated ad infinitum, to the medical and occupational detriment of the affected employee.

We wish in no way to imply that the accumulation of these shadows in a chest by any individual should be encouraged. On the contrary, we believe that proper exhaust ventilation should be immediately established wherever the exposure may be severe enough to cause siderosis. We feel this whole subject offers a challenge for further exploration to the clinician, the roentgenologist, and the pathologist, to establish the complete and thorough picture of its etiology and its effects. We do not believe, however, that industrial hygienists and those in charge of plant operations should wait for these final conclusions. Theirs, we believe, is the greater challenge, to prevent its occurrence as completely and as early as possible, and by the prevention of severe exposures convert the final clinical conclusion into a matter of academic interest rather than allowing it to remain a subject of clinical and medical importance.

SUMMARY

1. Arc-welder's siderosis is today a well established condition.

2. The rejection of several arc-welders by the army induction station in Cleveland led to the X-raying of 83 of their fellow-workers of which 59 displayed positive findings.

3. It is not necessary that the poorly aerated space in which the welder is exposed to high concentrations of welding fumes be small.

4. Some of the most extensive cases observed in this group of welders had been welding only about six years, but no siderosis was found in cases welding less than six years.

5. Arc-welder's siderosis has not predisposed to tuberculosis or reactivated old calcified lesions in the lungs in this group of welders.

6. Prevention of arc-welder's siderosis can only be successful by necessary ventilation, no matter how large the working space, to protect the welder from inhalation of highly concentrated welding fumes.

7. All evidence to date indicates that arc-welder's siderosis is not a hazard to the health of a workman, but a serious potential menace to the mental stability of the welder if not soundly evaluated by the physician and intelligently interpreted to the affected welder and to the prospective employer.

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Common Disorders of the Digestive Tract

A series of 1,000 patients in private practice complaining of digestive disturbances is presented.

One out of every four was found to have some organic disease of the digestive tract. The most common lesion found was peptic ulcer, which occurred in about one-half of the cases.

Gallbladder disease was found in one-third of the cases.

Cancer of the digestive tract was found in 12½ per cent of those with organic disease.

A group of miscellaneous disease including diverticulosis, cirrhosis, cardio-spasm, esophageal ulcer, amoebic dysentery, ulcerative colitis, and chronic appendicitis was found in the remainder of the group.

Early dagnosis of most of the cases was possible because of complete examination, and this procedure is amply justified by the findings.

The often repeated statement that only five per cent of illnesses require extended examination does not apply to patients with digestive complaints.

The treatment of early lesions resulted in excellent therapeutic results except in the cases of cancer, where diagnosis was made too late to be of any value.—Sigurd W. Johnsen, M.D., Passaic, N. J. Jr. of Med. Soc. of N. J. Vol. 41, No. 6, June, 1944.

Subungual Hematoma

When a hematoma occurs in a traumatized finger, separating the nail from the nail bed, there is usually considerable pain. The customary "drilling" of the nail to allow for the escape of blood should **not** be done. Too often organisms introduced at the time of drilling find a welcome medium of blood in which to grow, the "drill" holes seal over and infection follows. Instead, the side of the nail should be lifted up to evacuate the blood and a moist dressing provided. —R. F. Hedin, M. D., Red Wing, Minn., Minnesota Medicine, Vol. 27, No. 6, June, 1944.

Ménière's Syndrome

JACK A. RUDOLPH, M.D.

THE typical Ménière symptom-complex is characterized by deafness, vertigo, and tinnitus. Attacks usually occur suddenly with vertigo, accompanied by nausea, vomiting and spontaneous nystagmus in the severe seizures. The tinnitus is often bilateral and varies in intensity.

The allergic reactions in the labyrinth are usually characterized by sudden vertigo, with inconstant cochlear disturbances. These attacks of vertigo are usually accompanied by some nystagmus. High pitched tinnitus and a slight loss of hearing may precede, accompany, or follow the attacks. After a period of from one to 48 hours the attacks may subside. Hypersensitive individuals subject to the allergic type of headaches not infrequently have quite marked dizziness either preceding or following the attacks.

THE MECHANISM

There has been considerable speculation as to the mechanism concerned in the production of Ménière symptom-complex. In 1929, Portman[1] reviewed the various theories of the vasomotor affections of the internal ear as presented by leading observers on this subject. Most of the theories concern themselves with the part played by the vascular mechanism and the sympathetic nervous system. An opinion worthy of note expressed by Quinke[2] is that Ménière's syndrome is due to an involvement similar to that which exists in angioneurotic edema. There has also been concern as to whether the pathologic physiology involves the end-organ ,the tracts, or the various brain centers. Kobrok[3] agrees with Quinke's theory of the causation of Ménière's disease. He considers the mechanism to be a very unstable vagosympathetic nervous system and a local labyrinthine disturbance.

In the treatment of diseases of the labyrinth, Wasowski[4] found that parenteral injections of adrenalin relieves many causes of tinnitus aurium and cerebral vertigo. He did a number of animal experiments and made some interesting observations in this regard. Kuhn[5] made similar observations with respect to patients having hearing defects and gives a report on this.

ALLERGY A CAUSE

In 1923 Duke[6] presented evidence that allergy may be one cause of Ménière's syndrome. He stated that the pathology may be either the labyrinth, or peripheral end organ, the primary neuron or vestibular nerve proper; its tracts or the central nuclei in the medulla or the midbrain. Other lesions resulting from the acute infectious diseases, syphilis, hemorrhage into the labyrinth, tumors, abscess or traumatic injuries may have the same effect. Duke reported a group of five cases, two of which he described in detail. The relief of symptoms in patients was obtained both by the use of epinephrine and by avoidance of substances to which the patients were sensitive.

Two cases similar to those reported by Duke were also reported by Rowe.[7] Both of Rowe's patients were relieved by the administration of epinephrine and the attacks of dizziness were reproduced by the deliberate feeding of the offending foods.

In 1933 Malone[8] reported two cases of so-called Ménière's syndrome caused by hypersensitiveness to orris root and house dust. The patients were relieved of symptoms by desensitization treatment. A similar case was reported by Yandell[9] in which orris root was the offending agent. The patient had periodic attacks of intense vertigo, tinnitus, nausea and vomiting for a period of fourteen years. These attacks were followed by headaches. The patient gave a history of having had urticaria. Attacks were precipitated upon orris contact. Skin tests showed a two-plus reaction to house dust and a four-plus reaction to orris root. The patient was successfully desensitized to orris root with relief of symptoms.

In 1931 Vaughn[10] reported an allergic patient who manifested a great variety of neurologic manifestations among which there occurred several attacks of Ménière's disease. In this case, evidence was presented to indicate that angioneurotic edema of the brain substance was the cause of the various manifestations described. Dedering[11] reported three cases of Ménière's disease also associated with angioneurotic edema.

According to the observation of Levy,[12] tin-

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Submitted March 1, 1944.

nitus, with or without Ménière's disease may be of allergic origin. Levy reported a case of a woman with tinnitus caused by sensitivity to dog hair; removal of contact produced an immediate relief of symptoms.

In a group of 83 patients with an essential Ménière's complex Vogel[13] found that 5 had hay fever; 9, urticaria; 15, vasomotor rhinitis; 5, asthma; 14, gall bladder symptoms, 4, stomach ulcers; and 3, epilepsy. He does not classify Ménière's among the allergic diseases, but stated that the former frequently occurs in initiative states of the vegetative nervous system.

Proetz[14] reported a case of Ménière's disease of allergic origin in which the patient complained of intermittent tinnitus and vertigo for a period of five years. Two exceptionally severe attacks had occurred. The first one was preceded by an increased deafness in the right ear associated with nausea and vomiting; the second severe attack was not preceded by deafness but the vomiting was protracted, lasting about one hour, after which the vertigo slowly disappeared. Allergic study revealed that the patient was sensitive to milk, butter and cheese. Following avoidance of these foods the patient became symptom free. Repeated attempts to eat these foods would produce symptoms. This patient also had an iodide sensitivity, which would produce headaches and tinnitus.

CONCLUSION

Definite evidence has been presented to indicate that allergy may produce lesions of the internal ear, its nerve tracts, or brain centers, producing the Ménière type of symptoms. Milder manifestations of internal ear involvement are characterized by tinnitus or dizziness without other symptoms. The involvements of the nerve mechanisms concerned may be explained on the basis of an angioneurotic edema which is also believed to be the fundamental lesion in the production of allergic headaches.

REPORT OF A CASE

Mr. M. S., age 59, retired business man, was referred in February, 1940, with a history of recurring attacks of vertigo, tinnitus, accompanied by nausea, of 14 years duration. His first attack was apparently so severe that he was found on the floor of his office, rushed to the hospital and given oxygen. A diagnosis of heart disease was made according to the patient. The subsequent attacks were extremely severe, and usually incapacitating, and lasted from 24 hours to 3 to 5 days. They recurred so frequently that the patient was seldom free for more than 3 or 4 days.

Except for an attack of urticaria in his early teens the history was unimportant. Prior to seeing this patient, he had been subjected to a host of investigative procedures and treatments for these attacks. In addition to the constant use of numerous types of drugs given by various physicians for symptomatic relief both here and abroad, he received the following specific measures listed in chronological order: Refraction of the eyes, complete otologic examination, including a study of the patency of the eustachian tubes, Barany tests, a systematic course of gallbladder drainages and colonic irrigation twice weekly for 14 months, tonsillectomy, submucous resection, removal of remaining teeth, spinal puncture, encephalogram, 15 chiropractic and 25 electrotherapeutic treatments, and finally a long course of hypodermic injections of undetermined type. All of these failed completely to provide any relief of symptoms.

Thorough allergic study of this patient, including a complete personal history and complete cutaneous testing, revealed a large number of skin reactions, with complete sensitivity clinically to the following foods: pork, potato, peas, prunes, egg, to dust and to staphylococcus aureus vaccine.

Following the complete exclusion of these foods from the diet, together with recommendations for the preparation and maintenance of a dust free environment and specific desensitization to dust and to staphyloccus aureus vaccine, marked improvement occurred within three months and for the following two years of constant observation not a single attack occurred.

The patient left retirement and has been able to carry on and operate a large and successful insurance agency. It seems unnecessary to emphasize the amount of discomfort and expense which this patient might have been spared if allergic studies had been done in the beginning instead of the end.

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In a community in which there are no cases of Tinea Capitis but in which the children may come into contact with the infection, the school board would be well advised to purchase a Wood light and have the school nurse instructed in its use.—New York State Jr. of Med. Vol. 44, No. 12, June, 1944.

Radiation Therapy as a Method of Treatment in Non-Malignant Conditions

LOUIS M. PIATT, M.D.

RADIATION therapy as a method of treatment in non-malignant disease has not gained the headway it deserves in spite of the rather early knowledge, soon after its discovery, of its favorable effect in the treatment of many kinds of acute and chronic inflammations. The reports in the literature of X-ray irradiation in general practice are very scanty. What has been most evident to the radiologist for years and found mostly in radiologic literature should now be apparent to everyone, namely, that it is a life saving procedure which may prevent general septicemia and other serious complications.

Radiation does not interfere with other means of controlling infection but on the contrary is a valuable adjunct. In the last 15 years the use of roentgen treatment in disease other than that of malignancy has become somewhat more frequent. Treatment of inflammations with X-rays was first practiced in Europe and was not generally adopted in this country until after the First World War.

What is the reason that in spite of the reported good results, this branch of therapy has not advanced more rapidly? Why do many physicians hesitate to entrust the patient to an experienced therapist even today, especially those patients in whom other therapeutic measures have failed?

The opinion is that several factors contribute to this confused status of roentgen therapy in non-malignant conditions namely that there is a multiplicity of theories as to the mechanism of the action of roentgen rays in inflammation and that the exact nature of the biological reaction of tissue is not yet fully understood. The patient on the other hand is hesitant because beneficial effects are imperceivable since X-rays are neither visible nor sensible and because of the relative high cost of treatment necessitated by the enormous expense in installation and upkeep of therapy units.

GENERAL CONSIDERATIONS

It is not easy to explain the clinical evidence of improvement resulting from irradiation in inflammatory disease in the absence of experimental proof of bactericidal effect of X-rays. Clinical therapists, however, have long realized that the irradiation effect is not due to bacterial destruction but rather to the production of antibacterial effect in living tissues and the subsequent availability of endotoxins which destroy bacteria and aid healing.

Desjardin believes that in acute inflammation the earliest evidence of reaction to an irritant is a temporary contraction of the blood vessels in the affected region which is soon followed by an expansion and an accompanied increase in the flow of blood resulting in hyperemia, seepage of plasma and a local leukocytosis.

The migrating leukocytes are chiefly polymorphonuclears which destroy bacteria and other noxious material and in turn liberate substances (proteolytic ferments and thrombin) which combine with fibrinogen of the plasma to form fibrin, as they themselves disintegrate and become so-called pus cells. The large mononuclear leukocytes act as scavengers of dead bacteria, degenerated leukocytes and broken-down tissue cells.

The principal function of the lymphocytes appears to be that of an antitoxic action. The antibodies and ferments liberated by the destruction of leukocytes in and around the inflamed area are the effective agents.

Certain experiments have shown that coagulated plasma limits the spread of infection by the thrombotic sealing of the arterioles, capillaries and lymphatics. Thus bacteria and other foreign substances are fixed at the site of inflammation.

As stated before, the action of roentgen rays on inflammation is not attributed to a direct bactericidal effect but indirectly on the body fluids (blood, plasma and lymph). The direct action of the rays appears to be on the blood corpuscles and tissue cells of different kinds, the cellular changes being the important factor.

The sensitivity of leukocytes to roentgen rays is well established. Of these leukocytes the lymphocytes are the most sensitive to irradia-

Submitted April 29, 1944.

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tion. The large mononuclears and polymorphonuclears are only slightly less so. Correlation of the above factors therefore indicates that the greater the degree of leukocytic infiltration and acute inflammation the greater the effect of irradiation.

There is no sharp line of demarcation between acute and chronic inflammation. The distinction between them is largely arbitrary, the difference being that in chronic inflammation the tendency to fibrin deposits is diminished and the amounts of connective tissue and products of cellular degeneration vary. There is also preponderance of lymphocytes with the presence of eosinophiles and giant cells.

Pendergrass and Hodes have expressed the opinion that the action of roentgen rays on acute infections is due to vascular changes induced by irradiation rather than to leukocytolytic action.

However, in chronic inflammations the destruction of leukocytes may be of significance. Bisgard and others suggest that X-ray creates an antitoxic substance which neutralizes the effects of bacterial toxins and produces beneficial results.

This is something that can not be created in test tubes. The associated living human tissue activity is essential for production of the curative effect of irradiation, and for this reason the theories based on laboratory test tube investigation are not entirely applicable to human conditions. Neither is it always proper to translate observations of birds, guinea pigs and rodents to humans in the face of adequate demonstrations of real worth of X-rays in the treatment of human beings.

The remainder of this paper will be limited to brief observations of some conditions treated by roentgen rays and a listing of others successfully responding to roentgen therapy.

BURSITIS

Irrespective of the fact that this condition has been designated by a variety of names, the pathology present is essentially that of calcium deposited in pre-existing degenerated tissue and usually found about the greater tubercle of the humerus.

Numerous methods of treatment are cited and any of them may produce relief of symptoms and a cure. However the treatment of choice should be the one offering the shortest period of disability. With this criteria in mind the literature was reviewed.

The typical response especially in acute cases is a frequent aggravation of symptoms for 12 to 48 hours. This period is then usually followed by relief from pain and an increase in motion. Residual tenderness may remain for several days. Calcium deposits frequently disappear. In chronic cases similar response can be claimed except that the percentage of improvement is not as high. Statistical averages are as follows in acute cases: 65-70 per cent receive marked to complete relief; 10 per cent receive slight relief; 20 per cent receive no relief.

The treatment varies, depending on the size of the part and the judgment of the therapist. Filtered ray in the amount of 100 to 250R is given by cross fire and repeated at intervals of one to three days.

ARTHRITIS-SPONDYLITIS

Arthritis is still an uncontrolled condition despite all efforts at treatment and at best palliative measures give only transitory relief. X-ray treatments applied before anatomic changes in cartilage or bone are perceived give better and more continued results. Deformities of the articular bodies and ankylosis in atrophic arthritis can not be influenced by X-rays nor can the bony deformities of hypertrophic arthritis be changed.

Reports by Oppenheimer, Baker and Dekkers of results in the treatment of Marie Strumpfell's. Disease and rhizomelic spondylitis confirms the usefulness of irradiation therapy.

Smith, Freyberge, Lampe, and Goldhammer find roentgen therapy highly valuable in almost all forms of arthritis and in many instances the only method of therapy producing significant relief.

Resumé of statistical data is as follows: 60-70 per cent are markedly improved or free from symptoms; 20-30 per cent are slightly improved; 10-15 per cent are not improved.

The sedimentation rate is decreased in 41 per cent of cases. General well being and mobility of parts are definitely improved.

The treatment is usually carried out with a moderately filtered ray, the size of the portal depending on the location treated.

PNEUMONIA

The fundamental principles involved in pneumonia are the same as those for X-ray treatment of any other acute infection.

While sulfonamides are of great value in the treatment of pneumonia, indications are that X-ray therapy should be used in those patients who do not tolerate the sulfonamides well, in old people and in patients with serious diseases of the heart, liver or kidneys. Sulfonamides should not be used in conjunction with roentgen therapy.

Uhlmann of Chicago reports that in 50 cases of virus pneumonia treated with roentgen therapy the effect was dramatic. Temperature, respira-

tion and pulse improved quickly. He gave one or two treatments of 50-100R daily or every other day.

Pendergrass and Hodes state that irradiation shows better results in lobar than in bronchopneumonia and that in many cases marked relief was obtained in 12 hours after the first treatment. Curtis in reviewing the radiation treatment of pneumonia for nine years shows that the mortality was less than 5 per cent and complications so infrequent that routine roentgen therapy of pneumonia is in his opinion amply justified. Small doses of filtered ray seems to be the preferred quality.

ASTHMA

The patient chronically afflicted with asthma can now be afforded definite relief by irradiation. Kaplan and Rubenfeld in a recent study of 66 cases point out the fact that 72 per cent received relief from asthmatic paroxysms after irradiation. They also note that the longer and more severe the illness, the more favorable the response to irradiation.

There is frequently, however, an aggravation of symptoms preceding amelioration. Scott reports 121 cases treated with definite results. Maytum and Leddy treated 215 cases with good results in 79 per cent. Hull, Balyeat and Chont after treating two series of cases of 100 and 1529 report that they were able to control asthma in many individuals who previously failed to respond to other methods used. Our own limited experience with this condition has been quite satisfactory.

Practically all cases were treated with 200 KV. moderately filtered, given through 4-6 portals.

OTOLARYNGOLOGICAL CONDITIONS

In recent years the treatment of sinusitis by roentgen rays has become more popular. A group of cases were treated by X-rays and observed by roentgenologists and otolaryngologists in collaboration who concluded that 62 per cent of moderately severe cases received good results and that 81 per cent of very severe cases received good results.

Butler and Wooley report 450 cases treated by roentgen rays with 36 per cent cured, 55 per cent improved. Their experience also shows that the patients with hyperplastic membranes were more likely to be helped. Patients with atrophic rhinitis, fibrosis, and those having had radical surgery were least helped. Contrary to the belief of some rhinologists the author encountered no harmful effects as the result of radiation therapy.

A summary of conclusions is as follows:

1. Small doses of X-ray are more effective in acute cases.
2. Subacute cases respond best, the dosage being somewhat higher than in acute cases.
3. In children radiation offers excellent results.

It has been our experience and this confirmed by otolaryngologists and others that children X-rayed for diagnosis of mastoditis have frequently shown improvement of symptoms following the exposure to apparently small doses of X-ray.

The relief from pain and headache is the most striking effect. The symptomatic improvement is usually accompanied by a noticeable increase in discharge which may be the result of diminishing engorgement of the nasal mucosa. Recurrent attacks also seem less frequent.

Under this heading it may be in order to briefly discuss several other conditions responding successfully to roentgen therapy. Titche, Lawson, and Shillinger conclude that radiation therapy is a valuable means of treatment of otitis media and other inflammatory diseases of the ear and should merit wider use, but that it must not be used as a panacea for all disease.

Crowe and Burman recommend radiation in children as a method of treatment of deafness based on the obstruction of the eustachian canal by lymphoid tissue.

Ersner further recommends the use of roentgen rays in chronic otitis media, persistent otorrhea after mastoidectomy and cellulitis of the external auditory canal. Pohle suggests its use in adults with congested mucosa.

WOUNDS AND INFECTIONS

Penetrating, perforating and crushing wounds are becoming major problems of the military surgeon. Sufficient experimental as well as practical proof is at hand in industrial cases, that X-rays are an effective agent in controlling infections and if used early after injury is sustained will noticeably decrease the percentage of cases of infection.

SKIN

The use of radiation in the treatment of disease of the skin need only be mentioned very briefly since many good volumes cover this subject. Better trained therapists and more exacting methods as well as a better selection of cases has resulted in definitely establishing the value of irradiation in this field of medicine.

BENIGN PELVIC LESIONS

Radiation in benign pelvic conditions is too extensive a subject to permit anything but a brief resumé in this general discussion. The problem of hemorrhage in the climateric, uncomplicated by fibroids or cancer, is oftentimes solved by irradiation with X-ray, radium or a

combination of both. A diagnostic dilatation and curettage should precede irradiation therapy.

In recent years there has been an increasing tendency of replacing X-ray by radium in pelvic hemorrhage. The advantages of radium irradiation are:

1. The ease of application.
2. The treatment time required is shorter.
3. There is less radiation sickness.
4. The hemorrhage is stopped more readily.

However, radiation of the ovaries with X-ray is at times necessary if the hemorrhage does not completely cease after radium irradiation.

A large percentage of uterine fibroids are reduced in size from 50 per cent to complete disappearance after irradiation. Many of these have been under observation for years. Surgery is preferred in the large fibromyoma and palpable diseases of the adnexa.

A comparative evaluation of menopausal symptoms produced by irradiation and surgery in 334 cases are review by Brown, Peck and McGreer.

Of this series of cases: 73 per cent developed hot flashes after radiation castration; 86 per cent developed hot flashes after surgical castration (bilateral oophorectomy; 62 per cent developed hot flashes after radiation but not castration; 58 per cent developed hot flashes after hysterectomy with ovarian conservation.

Concerning libido, surgical and radiation effects are about the same. In short:

1. Irradiation is most applicable to women approaching menopause.
2. Irradiation is an efficient means of curtailing benign uterine bleeding.
3. Irradiation is preferred to surgery in menopausal patients because the risk is much less and hospitalization is not near as long.

MISCELLANEOUS

Any number of other non-malignant conditions responding to irradiation could be discussed. This would, however, entail a much lengthier paper than is intended. Hence some remaining conditions will be enumerated. Beneficial effects have been reported in myasthenia gravis, osteomyelitis, chronic mastitis, diphtheria carriers, keloids, trigeminal neuralgia, persistent nose bleed, hyperthyroidism, tubercular lymphadenitis, angiomas, post-operative parotitis, boils, furuncles, enlarged thymus, peritonitis and gas baccillus infection.

CONCLUSIONS

1. Reports of radiation therapy as a method of treatment in the general literature is scanty and is mostly found in radiological literature.

2. The use of radiation therapy in malignancies has overshadowed its use in non-malignant conditions.

3. The exact mechanism of the biological reaction to the action of roentgen rays is not fully understood.

4. There is no definitely standardized method of treating of any one condition. The method of treatment must therefore depend on the judgment of the therapist.

5. There is no longer any doubt that radiation therapy is of value in many kinds of acute and chronic inflammations, and as an adjunct to our armamentarium of treatment deserves trial before other more drastic methods are instituted.

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Obstructions and Urinary Affections

Kidneys, like filters, cannot function well against back pressure, regardless of where the obstruction happens to be. Not infrequently the freedom of hydronephrotic kidneys from infection unfortunately is not an advantage but a disadvantage because the absence of pus in the urine often results in so much delay in the diagnosis that, as a consequence, renal function may be seriously impaired before the obstruction is detected. In patients with this condition failure to recognize the primary cause of the damage to the kidneys naturally results in inadequate treatment.—Edgar G. Ballenger, M.D., Atlanta, Jr. of the Florida Med. Assn., Inc. Vol. XXXI, No. 1, July, 1944.

Operability Versus Curability of Cancer of the Breast

U. V. PORTMANN, M.D.

CANCER of the breast is treated by surgery, irradiation with roentgen rays or radium, or by combinations of these procedures. It is difficult to determine the indications for and the limitations of different methods of treatment because of conflicting reports about results. There is considerable variation in the results of operation as reported by different surgeons, and there is equal divergence of opinion concerning the efficacy of irradiation.

Certain comparisons between the results of operation and those of irradiation indicate that irradiation is of no additional benefit and may even be harmful since the incidence of five year survival in patients so treated is no greater and may even be less. Other reports indicate that irradiation prolongs the life and economic usefulness of some patients. Reasons for these discrepancies will be discussed.

The results of operation reported by different surgeons vary from 15 to 50 per cent for five year survivals.[4] These reports are made by competent surgeons performing radical mastectomies according to modern standards under favorable conditions. Variations in results can not be attributed solely to possible differences in technic. The best explanation is that surgeons differ as to criteria of "operability," that is, in the selection of cases for surgery. Surgeons reporting low survival rates probably operate upon a greater number of cases with extensive involvement than do those reporting high survival rates.

OPINIONS DIFFER

Such differences of opinion concerning "operability" are illustrated in recent publications of two eminent surgeons. Cheatle believes that "The problem of the case being inoperable is easier to decide in certain instances than where it is operable. There can be little doubt that all surgeons would consider the case to be inoperable if an X-ray photograph—revealed metastases. The same conclusion would be made if the lymphatic glands in the upper axillary region were enlarged, hard, defined, or confluent; and where a similar state of things was found in the supraclavicular region. On the other hand operability is hopefully anticipated when there is no axillary involvement detectable or when only one enlarged lymph nodes can be found in the lowest part of the axilla. Unfortunately even in the latter circumstances the operation itself often reveals that the axilla is heavily affected and that the case is inoperable."[1]

On the other hand, Harrington says "Any lesion was considered to be operable if it was freely movable from the thoracic wall regardless of ulceration. In some cases, even if there were cutaneous nodules proximal to the tumor regardless of the presence or absence of palpable or axillary nodes, the lesion was considered operable. The same view of operability was held in most cases in which supraclavicular nodes were palpable, but were confined to one side—. Those conditions were considered inoperable in which a large growth was fixed to the thoracic wall and there was very extensive metastasis in the regional lymph nodes or metastasis to other distant parts of the body. A few patients who had metastasis that involved distant portions of the body were accepted for operations because of exceptional circumstances."[3]

OBJECTIVES

These surgeons obviously do not have the same objectives in operating upon patients with cancer of the breast; they also disagree about the indications for and the limitations of surgical procedures, or the definition of "operability". From a purely technical standpoint, if the objective is to remove as much malignant tissue as possible, whether or not the patients are benefited, all patients with cancer of the breast are "operable".

The late Dr. John B. Deaver, another eminent surgeon and authority on diseases of the breast, pointed out the fallacy of this objective: "The widespread disrepute in which cancer surgery is held by laity is due in large measure to a willingness—of many surgeons to accept hopelessly advanced cases for radical operation. The indications for palliative operations are seldom met with—and in the absence of such, any operation, the purpose of which is merely to remove as much malignant tissue as possible, should be strongly condemned. Operations of this type contribute nothing to the comfort of the patient nor to the prolongation of life, on the contrary, the

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end frequently is hastened by exciting the disease to more active growth."[2]

Differences of opinion concerning the indications for and the limitations of surgical procedures in cancer of the breast account for the ambiguous use of the terms "operable" and "inoperable," which should be discarded. "Surgically curable" and "surgically incurable" are preferable terms. These at least would define objectives for treatment and might lead to agreement about the manifestations of incurable cancer of the breast.

VALUE OF IRRADIATION

A matter of equal importance is the clarification of the reasons for uncertainty about the value of irradiation for cancer of the breast. Most reports of statistical comparisons between the results of operation alone and those of operation followed by irradiation give little if any consideration to differences in anatomical extent or degree of involvement in the cases compared.

In many instances, results in cases with recurrence or metastases and in those in advanced stages of the disease treated by irradiation are compared with results in primary cases with less extensive involvement treated by operation. Surgeons usually advise irradiation when they have reason to believe that they have not removed all malignant tissue, when the patient is obviously surgically incurable because of extensive involvement, or when local recurrences or distant metastases are present.

No justifiable comparison can be made between results obtained by irradiation of these patients and the results obtained by operation upon patients with less extensive involvement. If survival rates are the only basis for evaluation, conclusions drawn from such comparisons are erroneous.

CLASSIFICATION NEEDED

Equitable comparisons of results of treatment can be made only by classifying cases according to anatomical extent of involvement. Classifications of cases of cancer of the breast based upon either clinical or pathological criteria have been suggested, but none has been generally accepted.

In a statistical comparison of results obtained by operation alone and by operation followed by irradiation[4] it was discovered that classification of cases according to clinical or pathological criteria was not satisfactory. It was apparent that the anatomical extent of involvement was the most important factor governning the indications for and the limitations of methods of treatment and of prognosis, and that this could be ascertained best by taking into account both clinical and pathological findings. Therefore, a classification based on both clinical and pathological criteria was developed. It was recently improved and reported in an unpublished paper presented before the Section on Surgery of the American Medical Association on June 12, 1942.[5] Of course the classification suggested is only for primary cases of cancer of the breast. Those with metastases or recurrences which develop after operation must be considered in a different category.

CLASSIFICATION FOR CASES OF PRIMARY CANCER OF THE BREAST BASED ON CLINICAL AND PATHOLOGICAL CRITERIA

Group I	Skin—not involved Tumor—localized in breast and movable Metastases—none in axillary lymph nodes or elsewhere
Group II	Skin—not involved Tumor—localized in breast and movable Metastases—few axillary lymph nodes involved, none elsewhere
Group III	Skin—edematous, brawny red induration or inflammation not obviously due to infection, extensive ulceration, multiple secondary nodules Tumor—diffusely infiltrating the breast, fixation of tumor or breast to chest wall, edema of breast, secondary tumors Metastases—many axillary lymph nodes involved or fixed, no clinical or roentgenological evidences of remote metastases
Group IV	Skin—as in any other group or stage Tumor—as in any other group or stage Metastases—axillary and supraclaviscular lymph nodes extensively involved, clinical or roentgenological evidence of more remote metastases

A series of 1022 unselected cases of cancer of the breast is used to illustrate the applicability of this classification. Of the 1022 cases, 738 were classifiable; this number will be used in the tables. Of the remaining 284 cases, 174 were not classifiable because thay had been operated upon elsewhere and were first seen when recurrence or metastases had developed. Irradiation was given to 127 of these patients. In the additional 10 cases our records did not give sufficient information to justify classification.

Total cases		1022
Not classifiable:		
(1) Recurrence or metastases, no treatment	147	
(2) Recurrence or metastases, treated	127	
(3) Insufficient information in records	10	
		284
		738

TABLE 1

Incidence of Cases in Each Group

	No. Cases	Distribution in per cent				
		Group I	Group II	Group III	Group IV	Groups III & IV
Total Cases	738	24.4	28.4	30.0	17.2	47.2
Classifiable, no treatment	133	28.5	12.0	14.3	45.2	59.5
Classifiable, treated	605	23.5	32.0	33.3	11.1	44.4

TABLE 2

Incidence of 605 Classifiable Cases in Each Group According to Methods of Treatment

Method of Treatment	No. of Cases	Per cent of treated Cases	Distribution in per cent				
			Group I	Group II	Group III	Group IV	Groups III-IV
Operation only	190	31.4	39.0	34.2	19.4	7.4	26.8
Preoperative X-ray	24	4.0	4.3	21.7	56.5	17.5	74.0
Postoperative X-ray	270	44.6	22.6	36.0	36.0	5.4	41.4
Irradiation for Recurrences or Metastases	70	11.5	10.0	40.0	45.7	4.3	50.0
Irradiation only	51	8.4	0	0	45.1	54.9	100.0

Classifiable:

(1) Classified on clinical finding only, not treated 127

(2) Classified on clinical and pathological findings, treated 605

738

CLASSIFIABLE CASES

Table 1 shows the incidence of the 738 cases in each of the four groups. The 133 untreated cases were classified on the basis of clinical findings alone. These included cases in which treatment was not justified because of the advanced stage of the disease, those who refused treatment, and those treated elsewhere. Of the untreated cases, the percentage classified in Group I may appear somewhat higher, and in Group II somewhat lower, than might be expected from comparison with the corresponding groups of treated cases. This is explained by the fact that those with small movable tumors and without palpably enlarged axillary lymph nodes were placed in Group I on the basis of clinical findings. Untreated cases with small movable tumors and one or two enlarged nodes palpable in the lower axilla were placed in Group II; however, as in the case of Group I, more extensive involvement, which might have been discovered at operation, would have resulted in their being placed in Group III. Other untreated classifiable cases with clinical manifestations of extensive involvement but without evidence of distant metastases were placed in Group III and those with clinical or roentgenological evidence of distant metastases in Group IV.

Table 2, classifying cases according to methods of treatment, demonstrates the following: (1) Almost half (47.2 per cent) of all primary cases were in advanced stages of the disease (Group III plus Group IV) when first examined. (2) In Group III and IV the proportion of patients receiving irradiation was greater than the proportion treated by operation only. These observations indicate that the principal reason for uncertainty about the results of irradiation is that there is a higher proportion of cases in advanced stages of disease in series receiving irradiation than in those having only operations. It also emphasizes the need for classifying cases of cancer according to clinical and pathological manifestations of anatomical extent of involvement when comparing methods of treatment.

RESULTS OF TREATMENT

Among the benefits of treatment prolongation of economic usefulness and palliation should be considered, but since they can not be calculated statistically, survival rates are the accepted criteria for evaluating results of treatment. Table 3 compares the results in advanced cases of operation only with postoperative irradiation to determine whether this prolongs life. The highest survival rates among those treated by operation only occur in Groups I and II. If irradiation is of benefit, it should be evident from the results obtained in advanced stages of the disease, Groups III and IV. Only these groups have been tabulated.

The table shows the percentage of patients in Group III and IV known to be alive in each of five succeeding annual periods. Those dying of any cause or not traced were considered to have died of cancer. The proportion of survivals each

TABLE 3

Survival Rates in Groups III and IV According to Methods of Treatment

Method of Treatment	No. Cases	Per cent surviving at end of				
		1 year	2 years	3 years	4 years	5 years
All Cases in Groups III and IV	268	68.6	40.2	23.5	13.4	8.9
Operation only	52	51.9	23.0	9.6	5.8	5.8
Preoperative X-ray	18	72.2	38.8	22.2	15.8	5.6
Postoperative X-ray	112	75.0	50.0	30.3	18.7	13.4
Irradiation for recent metastases	35	82.9	60.0	42.8	14.2	11.4
Irradiation only	51	62.7	23.5	9.8	6.0	4.0

year was higher in the series given postoperative irradiation than in the series having operation only. Up to the end of the fourth year the percentage of survivals is higher in cases given irradiation than in those having operation only. The yearly survival rate of patients having irradiation only is as good as that of patients having operation only.

CRITERIA OF INCURABLE CANCER OF THE BREAST

No patient in Groups III or IV was "cured". All had clinical or roentgenological evidence of cancer. Moreover, when the histories, physical examinations, and surgical and pathological findings of the cases were studied, it was found that most patients in these groups had when first examined one or more clinical or roentgenological manifestations that indicated incurability. These have been listed as follows:

The Skin

1. Edema (orange or pig skin) of more than slight extent
2. Ulceration of more than slight extent
3. Brawny red and inflamed, not obviously due to infection
4. Multiple secondary nodules

The Breast

1. Diffusely edematous
2. Diffusely infiltrated
3. Multiple secondary tumors
4. Fixation to chest wall

Metastases

1. Axillary lymph nodes numerous, extensively involved, and fixed
2. Supraclavicular lymph nodes or edema of arm
3. Involvement of contralateral breast or lymph nodes
4. Remote metastases in bones, lungs, or other viscera

Patients with these criteria are "operable" because there is a technical possibility of removing some malignant tissue, but since all of it can not be removed they are "surgical uncurable". There is little justification for subjecting patients with clinical manifestations of incurability to radical operations. There is considerable evidence that fewer of the patients treated by operation survive one year than those not undergoing operation. They should be treated by irradiation alone. Under this treatment just as many or more survive; their economic usefulness is prolonged; and they receive palliation.

CONCLUSIONS

1. "Operability" and "curability" of cancer of the breast are not synonymous terms.
2. Series of cases of cancer analyzed statistically for the purpose of comparing methods of treatment should be classified according to clinical and pathological evidence of anatomical extent of involvement.
3. Certain clinical manifestations of incurable cancer of the breast can be listed as the "criteria of incurability".
4. Patients with one or more of the criteria of incurability should not be subjected to radical operation but should be treated by irradiation alone.
5. In addition to its palliative effect, irradiation prolongs the life and economic usefulness of some patients with cancer of the breast.

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Acute Cor Pulmonale

The majority of cases of acute cor pulmonale are diagnosed as coronary occlusion, and it is not until after the electrocardiogram is made and shows the rapid reversion to normal that the true diagnosis is realized. Then in retrospect all the events become clear.—J. A. Ossman, M.D., and J. DeVoine Guyot, M.D., Jefferson City, Mo. Jr. of Missouri State Med. Assn. July, 1944.

Cordotomy

EDWARD W. SHANNON, M.D.

CORDOTOMY is now an accepted neurosurgical procedure for the relief of pain which is mediated over the lateral spinothalamic tract.

Gowers suggested in 1879 that pain and temperature were conducted over a special tract in the spinal cord, but little attention was paid to this suggestion. In 1904 Spiller had a patient at the Philadelphia General Hospital who had complete loss of pain and temperature sensation in his lower extremities with preservation of tactile sensation. A year later at the postmortem examination of this patient a solitary tubercle was found in the right lateral spinothalamic tract, and at a higher level on the left side the same tract was also invaded by another solitary tubercle.

It was this finding which led Spiller, in 1911, to suggest surgical section of the anterolateral columns for the relief of intractable pain in malignant disease.

A year previously, Cushing, in discussing the relief of intractable pain, wrote, "There is another form of palliation which may save from much suffering the unfortunates who have a malignant (metastatic) involvement of the cord which is beyond surgical attack—namely the deliberate transection either of the entire cord or of the posterior columns alone, cephalad to the lesion".

So far as I have been able to find, this radical procedure was only carried out once and that by Cushing in 1916. At that time Cushing did a complete section of the cord in the thoracic region of a woman who had severe pain from a metastatic carcinoma of the spine. The patient lived six months and during this period was completely relieved of her pain.

Previous to the advent of cordotomy, rhizotomy was used for the relief of intractable pain. After the discovery that the posterior roots carried pain, Dana suggested that pain might be controlled by section of these roots, and Bennett carried out this procedure in 1886. This operation does give relief of pain, but it has the disadvantages that the root section must be very extensive and the area denervated is practically useless, as all forms of sensation are lost in the denervated areas.

FIRST CORDOTOMY

In 1912, E. Martin performed the first cordotomy following Spiller's suggestion that "if division of the anterolateral columns alone will remove pain, it may be possible, if the other parts of the cord be left intact, to avoid paralysis of the lower limbs and of the bowels and bladder by this operation". This first cordotomy was bilateral and was performed for relief of intractable pain secondary to malignant growth. The patient was rendered entirely free of the original pain.

Caldwalader and Sweet, also at the suggestion of Spiller, sectioned the anterolateral columns bilaterally in two dogs. Immediately after operation they noted a paralysis but it disappeared rapidly and was replaced by a very marked ataxia. These two dogs had a definite, though incomplete, loss of cutaneous sensation for pain and for extreme heat. This experimental work also showed pain and temperature to be mediated over the anterolateral tract and made surgeons more willing to carry out this rather radical surgical approach for the relief of pain.

That this operation was not readily accepted, is shown by the fact that until 1926, when Peet reported 19 cases, there were only 26 other cases on record.

IN GASTRIC CRISES

In 1915, Beers performed the first cordotomy for the relief of the pain of gastric crises, in spite of the fact that Spiller had stated in his original article that cordotomy would not affect them. Since then the pain due to gastric crises has frequently been treated by cordotomy. There are some unfavorable reports, but it is thought that these failures were probably due to an inadequate section at too low a level.

Hyndman and Jarvis have even gone so far as to state that bilateral cordotomy guarantees relief of pain from crises, provided the level and section are adequate. They also state that the vomiting associated with crises is cured by cordotomy, but Oldberg does not agree with this. When cordotomy is performed because of gastric crises it should be bilateral and the sensory level should extend as high as the nipple line.

The use of cordotomy has now been extended to intractable cases of gastric crises, post-

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herpetic neuralgia, amputation stump pain, tabes dorsalis, and Peet has performed a bilateral cervical cordotomy for the relief of pain secondary to a chronic infectious arthritis. This same operation has also been used for the relief of thalamic pain.

Frazier, Dewey and Rowe concluded that thalamic pain is the result of two factors, namely: a lesion of the pain damping system of the posterior spinal tracts within the optic thalmus, and of such mechanisms as prevent the summation and amalgamation of after effects, etc., and secondly a continuous slight stimulation of the peripheral pain fibers. They concluded that the method of relieving these severe central pains is an extensive surgical interruption of the pain and other fibers in the anterolateral columns, having intact the posterior roots, horns and tracts.

Turnbull has reported one case of thalamic pain which was cured by a cervical cordotomy. The pain in this case was thought to be due to syphilitic endarteritis of one of the thalamogeniculate branches of the left posterior cerebral artery. This relief of pain suggested that peripheral stimuli are necessary for the production of central pain.

LOCAL ANESTHESIA FAVORED

The technical aspect of this operation is not difficult and, as Frazier stated, "The success or failure of this operation is wholly dependent on the accuracy with which the operator follows his instructions." Most men favor the use of local anesthesia, which makes it possible to test the sensory level immediately after the spinothalamic tract has been sectioned and if it is found that the level is not adequate more of the tract can be sectioned. There are others, however, who feel that general anesthesia is better, as the operation can be performed more safely and accurately on an unconscious patient.

TECHNIC DESCRIBED

The operation is performed by doing a laminectomy at a level which should be at least four segments higher than the desired level of anesthesia, due to the fact that some of the pain fibers ascend two or three segments before they cross the cord to ascend in the lateral spinothalamic tract. For pain in the lower extremities or pelvis the usual level is in the upper dorsal region. The sixth dorsal vertebra is closer to the surface than any other, and it is frequently used for this reason. However, if the disease is progressive and is apt to involve higher segments, it is well to do the cordotomy at a higher level than D6.

When the dura is exposed it is opened with a longitudinal incision. It is convenient at this stage to have some one compress the jugular veins, causing the cerebrospinal fluid to well up in the wound. This can be sucked away, and the field will remain dry while the cord is being manipulated. The dentate ligament, which marks the junction of the posterior and middle thirds of the cord, is grasped with a mosquito hemostat. The cord is then rotated gently and an incision made into the cord one to two mm. anterior to the dentate insertion to a depth of four mm. and carried ventrally to a point medial to the anterior roots. For making this section, either a Frazier cordotomy hook or a cataract knife which has been marked to the proper depth with a small piece of wax may be used. The cordotomy may be combined with rhizotomy at the same level to give a higher level of anesthesia. If a bilateral cordotomy is to be done, the incisions should be separated by at least 2.5 cm. in order to prevent a transverse myelitis. There are many who feel that a bilateral cordotomy should not be done in one stage, as post-operative complications are more prone to occur than if the operation is done in two stages. If the pain is limited to one side but the other side is likely to be implicated by the underlying pathology, many men feel that a bilateral cordotomy should be carried out.

DEPTH AND EXTENT

The depth and extent to which the cord should be sectioned has not yet been agreed upon by all. There are those who state the depth should be at least six mm. and the incision extend from the dentate ligament to the anterior root. Hyndman states that the incision should be three mm. deep and extend from two mm. anterior to the dentate ligament to three mm. mesial to the anterior root. It has been standard teaching that the fibers from the higher levels are more centrally placed in the lateral spinothalamic tract than are the fibers from the legs. Hyndman does not agree with this, however, and believes that the fibers from lower segments are situated posteriorly, and that fibers from higher levels are disposed more and more anteriorly. He has based this conclusion on a large series of cordotomies and believes that it may be possible to do a differential section of the lateral spinothalamic tract. Oldberg states that if the pain is from a visceral source it is well to section deeply so as to cut a portion of the anterior gray column, since he feels some pain is mediated in this column.

Figure I shows the extent of the section and it can be seen that, in addition to the lateral spinothalamic tract, the other ascending tracts which are cut are the ventral spinocerebellar, spinotectal, spino-olivary, and ventral spinothalamic tracts. Section of these tracts has no apparent harmful effect, and light touch is not disturbed even though the ventral spinothalamic

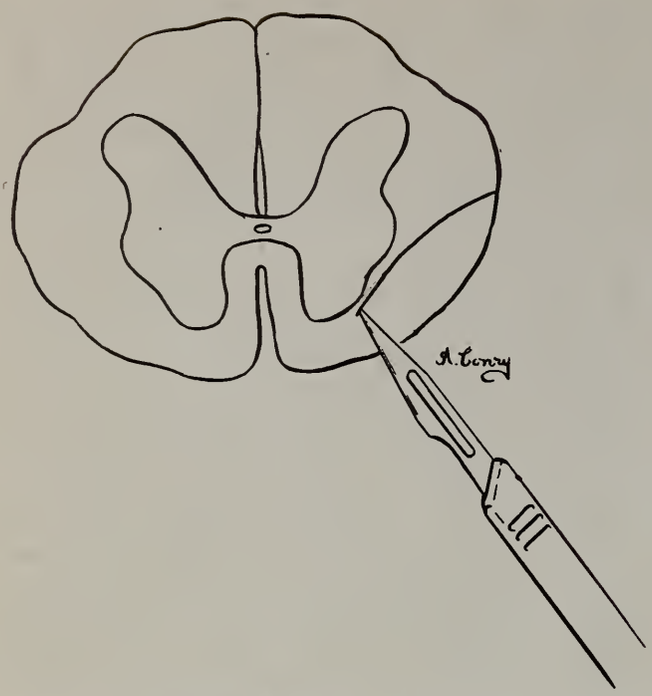


Figure I. Transverse section of the cord with cordotomy section.

tract is sectioned. The descending tracts which are involved are the tectospinal, rubrospinal, vestibulospinal and olivospinal tracts. These extra pyramidal tracts are not indispensable to normal tone and motor functions.

POST-OPERATIVE COMPLICATIONS

The post-operative complications consist of motor, genito-urinary, trophic disturbances and post-operative pain. The motor complications consist of paresis or rarely paralysis on the hemolateral side. This almost invariably clears up. Hyndman states that the loss of strength following cordotomy is a subjective complaint rather than an objective finding. In those of our cases which developed this complication it was very real, however. The explanation for the paresis or paralysis is that the pyramidal tract may have been sectioned, but this is a very rare occurrence and due to faulty technique. It is also thought that there may be some reactive edema about the cord incision and the pyramidal tract, being very close, is involved by it.

Figure II shows the arterial supply of the cord and is based on the work of Herren and Alexander. It is seen that the anterior radicular and anterior spinal arterial trunks supply the anterior horns, central gray matter, lateral horns, Clark's columns, anterior and lateral tracts including the anterior and lateral pyramidal tracts. If the vessels supplying the lateral pyramidal tract are cut during the section of the spinothalamic tract, this may account for the paresis.

The genito-urinary complications consist of retention and sexual disturbance. Following bilateral cordotomy the ability to have intercourse

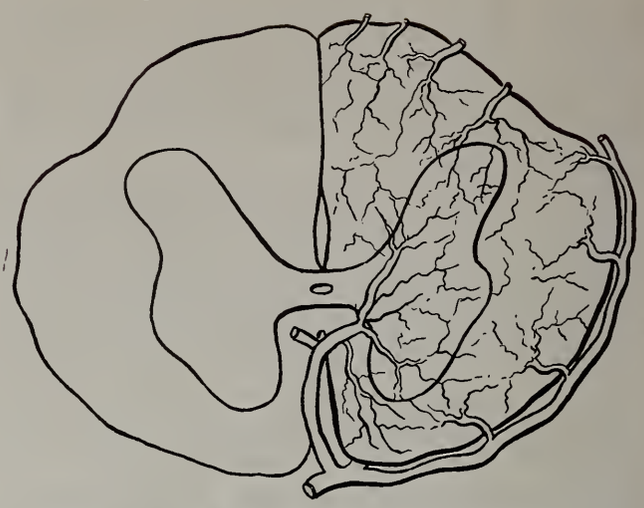


Figure II. The vascular supply of the cord (modified from Herren and Alexander).

or an orgasm is destroyed, even though the desire may still be present. This complication does not develop if the cordotomy is unilateral.

Urinary disturbances following cordotomy are common and more apt to follow bilateral than unilateral cordotomy. Bucy states that bilateral cordotomy is usually associated with temporary paralysis of the bladder. This may be permanent, however. In a series of cases of bilateral cordotomies for intractable pain of tabes dorsalis reported by Kahn and Barney, almost half of them remained incontinent. These men point out that tabetics are more prone to develop urinary disturbance than non-luetics. Most men report that if retention does occur, in non-leutics, it clears within two weeks. If the patients are placed on indwelling catheters it is wise to give them one gm. of sulfathiazole twice a day as a urinary infection prophylactic.

Cordotomy, per se, does not cause trophic disturbances. Many of the patients who have cordotomies are in poor physical condition and bed-ridden and consequently great care must be taken to prevent the formation of bed sores in these debilitated persons. Tabetics are prone to trophic disturbances, so when analgesia is produced surgically these patients must be very closely watched to prevent the formation of pressure sores.

Occasionally following cordotomy the patient will complain bitterly of girdle pain at the level of the cord section. This pain is due to manipulation of the posterior roots and is proportionate in severity to the dgree of manipulation of these roots. This complication clears up without specific treatment.

DELAY CONDEMNED

Many physicians wait until patients are very debilitated before they send them to the neurosurgeon for the relief of intractable pain. This is a practice which is to be condemned because at this stage the patients are usually in a very

rundown condition and poor surgical risks. The ideal time for a patient to have a cordotomy is as soon as the diagnosis of intractable pain has been made and it has been decided that the causative lesion is inoperable.

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Management of the Silicotic Patient

The general practitioner has a large share in the responsibility for the proper management of the silicotic patient. In addition to treating him for the relief of his symptoms, the physician must also advise him if and when a change of employment is advisable. The indications for such a change are fairly clear-cut, and there is no justification for taking a man from his job merely because he has simple silicosis. The factors which influence the decision to take a man from his job are the safety of the patient, his age, degree of disability, economic status, and his value to industry.—Paul J. Bamberger, M.D., Climax, Colo. Rocky Mountain Med. Jr. Vol. 41, No. 6, June, 1944.

Staphylococcus Osteomyelitis—A Case Report

I am of the opinion that there is need for discussion of the diagnosis and treatment of osteomyelitis, especially regarding the use of staphlococcus antitoxin.

Although we had an early negative blood culture and no way to determine the type of infection, it was reasoned that this patient had a staphylococcus infection with blood stream invasion. It was also reasoned that she was toxic and was not developing any antitoxin. It is well known that in severe staphylococcus blood stream infections that the toxin does the damage. Most cases of osteomyelitis are caused by staphylococcus and where there are chills, it is safe to assume that there is a blood stream invasion.

Staphylococcus toxin has an influence on the blood forming organs and prevents the development of white blood cells. Therefore, if the white count is falling rather rapidly as in this case it is safe to assume that the patient is toxic and is not making antitoxin. This clinical observation in my opinion is very important. I would rather base my concluson on this clinical fact than on any laboratory measurement of staphylococcus titer, because few laboratories seem to be able to make this determination accurately. Using this reasoning, it was decided to neutralize the staphylococcus toxin with staphylococcus antitoxin which we did with a dramatic response.

The obvious improvement which immediately followed the use of staphylococcus antitoxin proves that the infection was staphylococcus, that the patient was toxic and was not making antitoxin. After the toxin was neutralized penicillin prevented any new growth of bacteria and the patient won her battle without surgery.

Since penicillin is a bacteriostatic we now have three modes of defense in staphylococcus osteomyelitis but we should not lose sight of the advantages of staphylococcus antitoxin.

With staphylococcus antitoxin, we can neutralize the toxin and permit the patient to mobilize her forces of defense, by eliminating the effects of toxin on the blood forming organs and enhancing the patient's ability to develop new white blood cells. In this case the white count fell to 6,400 and three days following the use of antitoxin the white count was 25,800. Such response can not be ignored.

We now have a marvelous bacteriostotic in penicillin. We can neutralize staphylococcus toxin with staphylococcus antitoxin. The patient can build white blood cells if the toxin is neutralized and after all the white cells must destroy the bacteria.—F. L. Feierabend, M.D., Kansas City, Mo. Jr. of Kansas Med. Soc. Vol. XLV, No. 6, June, 1944.

Ruptured Saccular Aneurysm of the Circle of Willis In a Patient Cured of Gastric Carcinoma*

T. C. LAIPPLY, M.D.

Case History. J.M., a white male, 54 years old, entered the hospital December 9, 1931, complaining of epigastric pain which had begun six months previously. Roentgen examination revealed a small intrinsic tumor in the distal part of the stomach, presumably carcinoma. The patient refused operation, but the pain persisted and six months later he was admitted for surgical treatment. He was well developed and poorly nourished, with pallid skin and mucous membranes. There was a poorly defined, tender mass about 10 cm. in diameter in the left side of the epigastrium. The red blood count was 2,960,000 and the hemoglobin 40 per cent (Sahli). Roentgen study was characteristic of carcinoma of the distal third of the stomach. A partial gastric resection was performed by the Horsley method. The specimen revealed a well differentiated adenocarcnioma, 9 x 7 x 2.5 cm., with central ulcreation, extension through all coats of the stomach and metastases in several regional lymph nodes. The postoperative course was uneventful and the patient was discharged 13 days after the operation.

For the next 11 years and 7 months his health was good with no gastrointestinal symptoms. On July 24, 1943, at the age of 66 years, he again entered the hospital because of headache and backache of 10 days duration. The day prior to hospitalization, diploplia and ptosis of the right eyelid were noted. His temperature was 38° C., pulse 72, respiratory rate 18, and blood pressure 164/102. In addition to ptosis of the right eyelid the right pupil was larger than the left. The abdominal and cremasteric reflexes were absent. Laboratory examination revealed: Urine, normal; Blood, negative Kline exclusion test, 4.85 M. erythrocytes, 93 per cent hemoglobin (Sahli), 8,500 white blood cells; Spinal fluid, grossly bloody. Roentgen studies showed Paget's disease of the bones of the skull and a well functioning gastroenterostomy. For four days his temperature varied between 37 and 38.5° C. and he complained of persistent headache. After this the red cells in the spinal fluid gradually decreased in number and his headache and fever disappeared. The ptosis and diploplia persisted. He was discharged on his 15th hospital day, the clinical diagnoses being subarachnoid hemorrhage and hypertensive encephalopathy.

The patient's third and final hospital admission was four weeks later on September 3, 1943. Shortly before, while in bed, headache suddenly developed and was followed by vomiting unconsciousness and convulsions. At the time of hospitalization his temperature was 37.4° C., pulse 95, and blood pressure 204/100. He was unconscious, completely flaccid, had respiration of Cheyne-Stokes type and bilateral positive Babinski. The spinal fluid was grossly bloody. He did not regain consciousness and died 5 hours later.

*This is the twenty-second of a series of "Case Records Presenting Clinical Problems," selected by H. T. Karsner, M.D., from the Clinical Pathological Conferences of the Institute of Pathology, Western Reserve University, and University Hospitals, Cleveland.

Autopsy. (No. 8257) by A. J. Mantilla, M.D., disclosed a saccular aneurysm of the circle of Willis at the junction of the right internal carotid and posterior communicating artery. This aneurysm, 8 mm. in diameter, had ruptured intracerebrally into the right temporal lobe and lateral ventricle. Blood filled and distended the ventricular system and extended into the cerebellar subarachnoid space. There was also marked edema of the brain, slight recent hemorrhage into the pons and pituitary gland, slight hypertrophy of the heart, bilateral bronchopneumonia, arterial and arteriolar nephrosclerosis, and Paget's disease of the skull. The gastroduodenostomy was intact. Careful study, gross and microscopic, disclosed no trace of the original gastric carcinoma locally or in the form of metastasis anywhere in the body.

COMMENT

Saccular aneurysms of the circle of Willis and the proximal part of its branches have been known for over a century. From the literature between 1761 and 1938, McDonald and Korb[1] collected 1125 cases of saccular aneurysm of the arteries at the base of the brain, all of which were verified at autopsy or operation. In 1941 Richardson and Hyland[2] reported 53 intracranial aneurysms, which occurred in 40 cases. Twenty-seven such aneurysms were present in 22 of the 8442 autopsies performed at the Institute of Pathology of Western Reserve University. In this collected series of 1205 aneurysms, the location was indicated in 1103. Eight hundred fifty-one (77 per cent) were situated in the anterior half of the circle of Willis. Five hundred fifty-one of the patients were males; 604 were females; in 50 the sex is not stated. The age of the patient was given in 567 cases. Sixty-one (10.8 per cent) were less than 20 years old and 316 (55.6 per cent) were over 40 years of age. Thus these intracranial aneurysms are rare in infancy, uncommon before adolescence and most common in patients over 40 years of age. Nine hundred of the 1205 aneurysms had ruptured. Intracerebral penetrations of the hemorrhage was common, occurring most frequently in the frontal and temporal lobes. The cause of most "berry" aneurysms is not entirely clear but there is strong evidence supporting the existence of developmental weaknesses of the cerebral arteries, which probably plays some role in the formation of the aneurysms. The most common early symptom is marked generalized headache radiating down the back of the neck. This is frequently accompanied by vomiting. Other signs and symptoms include vertigo, irrationality, convulsions, un-

consciousness, numbness, weakness, hemiplegia, visual disturbance (due to pressure on optic or oculomotor nerve), prostration, chills, and bloody spinal fluid.

Of especial interest is the fact that 12 years after resection of the stomach for a carcinoma which had already metastasized, no trace of the tumor could be found. Pack and Livingston,[3] from a study of a large number of operable and inoperable cases of carcinoma of the stomach, found that 3.2 per cent survived for 3 years; 1.9 per cent for 5 years and 0.7 per cent for 10 years. These data refer to survival of the patient rather than to cure of the tumor. It might be thought that the high degree of differentiation of the cancer in the case reported herewith was significant, but even so, metastases had already occured. It is probable that the highly favorable result was due to the complete removal by surgical operation. Lack of success in treatment of gastric carcinoma is not invariably due to failure to recognize the disease in its early stage.

SUMMARY

This is a case of death due to rupture of a small saccular or "berry" aneurysm of the circle of Willis with hemorrhage into the cerebrum and extension of the hemorrhage through the ventricular system into the subarachnoid space. The case is significant in that partial resection of the stomach 12 years before death led to complete cure of a gastric carcinoma which had already metastasized to neighboring lymph nodes.

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Intestinal Obstruction in Pregnancy

Intestinal obstruction is rather a rare complication of pregnancy. It requires prompt surgical relief at this time as well as at any other time. The results as to maternal and fetal life vary directly with the promptness of operation. A patient who has had an obstruction long enough to require resection and perhaps drainage is very likely to have an abortion. Simple freeing of adhesions requires little manipulation and the pregnancy is only slightly endangered.—Wm. G. Cummings, M.D., and Philip H. Smith, M.D., Chicago. Illinois Med. Jr. Vol. 85, No. 6, June, 1944.

Value of Industrial Medical Service

There are two important phases connected with the effort to bring about better medical service in industry. One concerns the proving to the industrialist that a good medical service is necessary as well as profitable, and the other is to convince the medical profession that special training and experience are required to fit the doctor to perform a worth-while service for industry under conditions that will not interfere with but will help in the production of the particular product that it manifactures. Indiana is rendering outstanding service in both phases of the subject. The Industrial Health Conference last year and this second conference have provided information and directed attention to the sources from which doctors can obtain the needed knowledge to meet the requirements of industry. It has also brought to the attention of management the need for and the advantages of an adequate medical service.

It is generally agreed that on the whole the medical service in large industries has been good, but the large plants employ scarcely half of the industrial workers. Of the thirty million entimated persons engaged in industry, over half are employed in plants that have five hundred or less workers, and the great majority of these do not have a medical service worthy of the name. It is of this latter problem that the National Association of Manufacturers has particularly directed its attention. Much educational work has been done, based on actual surveys. It has been shown that where the factors entering into the situation are more or less the same, the accident rate is much lower in a plant that has a proper medical service. A survey based on 2,064 plants with 1,945,551 workers showed that in plants having a good medical service, there was a reduction of 62 per cent in occupational disease; 44 per cent in accidents; 29 per cent in absenteeism; 28 per cent in compensation; and 27 per cent in labor turnover.

In factories employing five hundred workers, an actual saving of $5,000 a year is possible by installing good medical protection. Here then we have proof that medical service in industry is not only humanitarian but that it is good business. The financial rewards are probably greater in many plants than the foregoing figures indicate. For instance, in one plant, after introducing the use of protective goggles, the direct cost of eye injuries in one year was reduced from $51,000 to $5,800. In a small plant the cost dropped from $2,000 per year to $50. Such experiences can be multiplied over and over. There also remain the important factors of good will, improved morale, less spoilage, more willing workers, and the greater achievement that is possible by healthy workers.—Victor G. Heiser, M. D., New York City. Jr. of Indiana State Med. Assn., Vol. 37, No. 6, June, 1944.

Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

PULMONARY TUBERCULOSIS ASSOCIATED WITH CONGENITAL HEART DISEASE

THIS study concerns the frequency of congenital heart conditions in a tuberculosis institution, the course of the pulmonary disease and the efficacy and advisability of collapse therapy in the face of the cardiac handicap.

In the course of 1,545 necropsy examinations of tuberculous individuals, seven cases of congenital heart disease were discovered, an incidence of 0.4 per cent. This incidence may be higher than in most other tuberculosis institutions due to the fact that one out of eight beds in this hospital is allotted to pediatrics. It is lower than that observed in institutions devoted entirely to the treatment of children.

The diagnosis made from the symptoms and physical examination of six additional patients coincided unusually well with the defects found in the seven cases that came to autopsy. They exemplify the grouping of cardiac anomalies known as the **tetralogy of Fallot.**

CASE REPORT

A picture of this condition is represented by this composite case report: The patient is a white youth in his lower teens. The history records cyanosis from birth or shortly thereafter and the diagnosis of congenital heart disease was made fairly early. At that time the child was placed on restricted activity and followed in a hospital out-patient department. He has had no evidence of congestive failure and has led a fairly normal life until the onset of the pulmonary disease.

Examinations show a young-appearing underdeveloped child not, as a rule, dyspneic, but with cyanosis and clubbing of the fingers and toes. The heart is enlarged in all dimensions, with a loud, harsh, systolic murmur at the base, usually associated with a systolic thrill. The lung findings are dependent upon the pulmonary pathology. Laboratory tests indicate a well-marked polycythemia and there are tubercle bacilli demonstrable in the sputum. Roentgenography and fluoroscopic examination demonstrate enlargement of both ventricles frequently more marked in the right and a prominent pulmonary conus. The venous pressure is within normal limits and the blood pressure tends to be normal or slightly decreased. In the electro-cardiogram are found right axis deviation with tall P waves, these often being notched. The pulmonary disease has not influenced the findings typical of the combined heart lesions making up the cyanotic group.

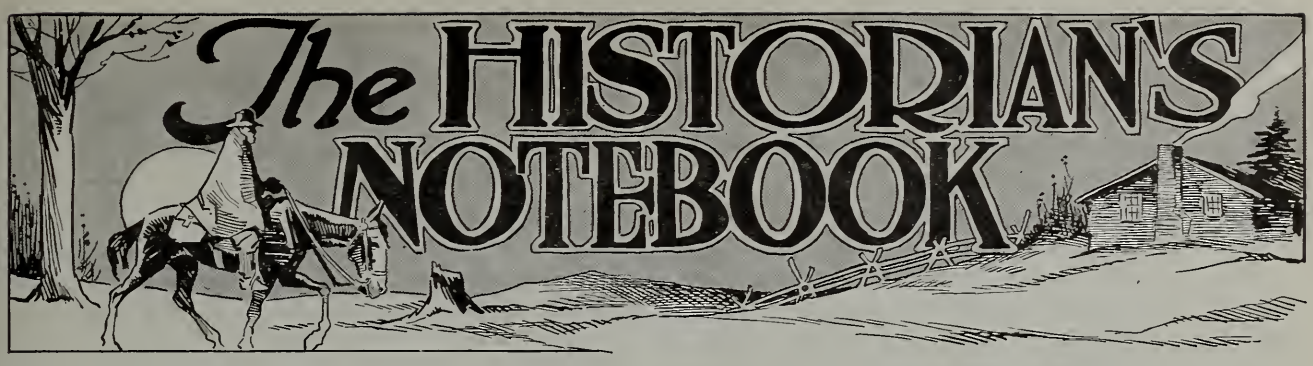
DISCUSSION AND SUMMARY

The onset of pulmonary disease in these cases was similar to that of patients without congenital heart disease. Some or all of the usual symptoms of tuberculosis were present in all cases. No difficulty was experienced in differentiating between the congenital heart disease and pulmonary tuberculosis since the congenital anomaly was diagnosed in all cases prior to the onset of the tuberculosis. The disease was moderately or far advanced on admission to the hospital in all but one case. The course of the disease and the lesions at autopsy were similar to those observed in patients without the cardiac hazard. The duration of life depended upon the extent of the disease on admission and the effectiveness of collapse therapy when that was used. The longest duration in the series of 13 cases was six years, the shortest courses were seven months.

As the lesions and other factors of the pulmonary infection are the same whether or not the patient has congenital heart disease and as the cause of death depends upon the pulmonary rather than the cardiac status, it is the lung rather than the heart which should be the focal point of therapy. When bed rest fails to arrest the progression of the tuberculous infection or cannot accomplish cavity closure it must be supplemented by collapse therapy in spite of the cardiac pathology. When this procedure is adopted late in the course of the disease the possibilty of arresting the tuberculosis is slight. The life expectancy of these patients even without the pulmonary complication is short. Nevertheless therapeutic measures, even hazardous ones, seem justifiable if they will prevent the patient from succumbing even more prematurely to tuberculosis.

In the group of cases here reported pneumothorax was instituted in five cases. In one case only was an effective pneumothorax established. In no case did collapse therapy increase the cardiac symptoms or lead to congestive heart failure.

It is recommended that congenital heart disease should not be considered a contraindication to thoracoplasty and in order not to deprive these patients of the few years of life expectancy due them, immediate operation may be more advantageous than a preliminary, often disappointing, trial of pneumothorax. — The Development of Pulmonary Tuberculosis in Congenital Heart Disease, Oscar Auerbach, M. D., and Marguerite G. Stemmermann, M. D., The American Journal of the Medical Sciences, February, 1944.



Kept by David A. Tucker, Jr., Cincinnati, Ohio

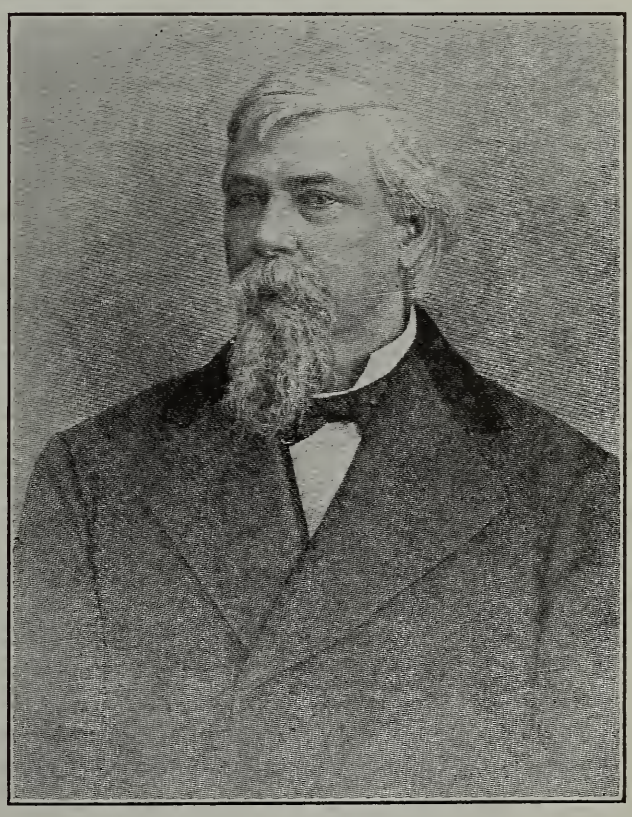
William Morrow Beach, M. D.

WILLIAM MORROW BEACH, youngest child of Uri and Hanna (Noble) Beach, was born at Amity, Madison County, Ohio, on May 10, 1831. He lived at Amity until he was four years old, and afterwards on a farm in Darby township until he was about 12, when his mother returned to Amity where he lived until he was 15, when he went as a dry goods clerk for Holcomb Tuller, in Dublin, Franklin County, Ohio, and in the same year, in another store in the same village, for Orange Davis.

In the Fall, he returned to Amity, ill, and was not again able to labor until the following year when on the 23rd of September 1847, when in his sixteenth year, he entered the store of George A. Hill & Co., of Pleasant Valley, for the astonishing salary of $36 a year, or about 11 cents a day, and board. His second year with them brought him $84, and for the third year was offered $800 in the main establishment—Pinney & Lawson, Columbus. This offer he declined, as the sedentary life, with no leisure for books, was distasteful to him; and at the commencement of the Fall term, he was a matriculant at the Ohio Wesleyan University, Delaware, Ohio, after the close of which he taught a school in Crabb District, Brown township, Franklin County.

In the spring of 1850 he commenced the study of medicine at Amity with Dr. James F. Boal, but suspended through the summer and traveled on foot over nearly all of the counties of Central Ohio, as an agent for the Ohio State Journal of Columbus. In the Fall of that year he entered the office of Professor Samuel Mitchell Smith of Columbus, as a student, and during that Winter attended a course of medical lectures at Starling Medical College—the first course delivered in the new building on State Street. He attended his second course there at the session following, and in February, 1853, was graduated an M. D.

He located at Unionville Center, Union County, where he remained two years, when he sold out his property and location to Isaac N. Hamilton, a brother to Professor John W. Hamilton, of Columbus, after which he spent about four months in the West prospecting for Congress lands, and



DR. BEACH

upon his return he settled, in September, 1855 in Lafayette, Madison County, Ohio, where he remained until he was commissioned by Governor Tod, as assistant surgeon in the Volunteer forces of Ohio in the service of the U. S. April 3, 1862, when he joined the Army at Shiloh, Tennessee,

Notes from the "History of Madison County, Ohio", published by W. H. Beers and Company, Chicago, 1883.

*Dr. Beach was President of the Ohio State Medical Society in 1885.

April 12, 1862, the Sunday morning after the battle. He was assigned to duty, temporarily, at brigade headquarters of General Wm. B. Hazen, and afterwards to the 20th Ohio Regiment.

On the third of May, 1863, he was further commissioned by Governor Tod as assistant surgeon of the 78th Regiment, Ohio Infantry Volunteers, to rank as such from April 20, 1862, which position he held until commissioned by Governor John Brough as surgeon of the 118th Regiment O.V.I., May 19, 1864, which commission reached him at Ackworth, Georgia, on the Atlanta campaign on the 9th of June, 1864, when he was mustered in and entered at once upon duty with his new command. This position he held until the close of the war, and until his muster out at Saulsbury, North Carolina in June, 1865.

He was with Grant when Holly Springs was sold out; was at Port Gibson, Raymond, Jackson, Champion Hills, and during the siege of Vicksburg, and his brigade had the honor of being the first to march within its lines on the morning of July 4, 1963. During the Vicksburg campaign he was Division Hospital Director of Logan's Division; and after the surrender, was in charge of the convalescent camp, and also of all the Confederate sick and wounded within the lines. He was with Blair on the Yazoo raid, with Sherman on the Meridan raid, and on the raid of Shreveport, Louisiana.

He re-enlisted or veteranized with his command for the remainder of the War, in the Spring of 1864, when the term of the 78th Regiment expired. He was in the Army of the Tennessee under Grant, Sherman, McPherson, Logan and Blair until the commencement of the Atlanta campaign when he was transferred by promotion into the Second Division, 23rd Army Corps, under Schofield.

He followed the fortunes of that Army up until the end of that campaign, and when Sherman started off on that long picnic "to the sea" he came North with Schofield, and was at Columbia, Spring Hill, Franklin and Nashville, and after the ruin of Hood's brave and magnificent army, was transferred with the 23rd Army Corps to Fortress Monroe, thence by sea to Smithville, at the mouth of the Cape Fear River and directly to the four days' siege of Fort Anderson, and then to Town Creek, and then across the Cape Fear at night to the siege of Wilmington, where we forced an evacuation of the works, and entered that long and bloodily disputed stronghold on Washington's Birthday, February 22, 1865.

On his way to Raleigh, after the junction with Sherman's "bummies" at Jonesboro, he heard of Lee's surrender and Johnson's capitulation soon followed. At the close of the War, he was Division Hospital Director of the Second Division, 23rd Army Corps, and one of the three surgeons of that division that constituted the "operating board".

He had campaigned for three years and three months in six different states; had been a witness to about 150 days of carnage, and had traveled, whilst campaigning in the army, more than 9,000 miles.

He is a member of the Society of the Army of Tennessee. After the close of the war he settled on his farm, two miles north of London, Madison County, Ohio, but continued in practice of his profession.

In the fall of 1869 he was elected by the Republican Party of Madison County to the State Legislature, and in the Fall of 1871, was elected to the State Senate by the counties of Madison, Clark and Champaign. He is a member of the Madison County Medical Society and has been its President; of the Central Ohio Medical Society; of the Ohio State Medical Society, and in the year 1881 was elected First Vice President; and is also a member of the American Medical Society.*

In 1860 he married Lucy E. Wilson, only daughter of James and Eleanor (Smith Wilson, born March 28, 1844). They had one child, a daughter, Mary.

Congress of Physical Therapy

Members of the medical profession and their qualified aides are invited to attend the 23rd annual scientific assembly and clinical session of the American Congress of Physical Therapy, to be held at the Hotel Statler, Cleveland, September 6-9. The annual instruction course will be given from 8:00 to 10:30 A. M., and from 1:00 to 2:00 P.M., Sept. 6, 7, and 8. The scientific and clinical sessions will be held during the remaining portions of these days and evenings. For information concerning the instruction course and details of the convention, write the American Congress of Physical Therapy, 30 N. Michigan Ave., Chicago, 2, Ill.

Surgeons to Meet in Philadelphia

The Ninth Annual Assembly of the United States Chapter of the International College of Surgeons will be held at the Benjamin Franklin Hotel, Philadelphia, October 3-5. Speakers on the "Service Night" program will include: Vice Admiral Ross T. McIntire, Surgeon General of the U. S. Navy; Major General George F. Lull, Deputy Surgeon General of the U. S. Army, and Dr. Charles M. Griffith, Medical Director, U. S. Veterans' Administration. There will be a scientific exhibit and a variety of motion pictures of operative procedures. Additional information concerning the meeting can be obtained by writing Dr. Moses Behrend, chairman of publicity, 255 South 17th St., Philadelphia.

Ohio Physicians Urged to Ask Congressmen to Back Miller Bill to Remove Threat to Medical Students; Acute Shortage of Doctors Seen Under Present Policy

AN acute shortage of medical care will threaten the United States, due to a drastic reduction in the number of physicians, unless steps are taken immediately to change the present regulations and policies of the Selective Service System and the armed forces in regard to medical and premedical students, in the opinion of officials of the American Medical Association and of the Ohio State Medical Association.

The cause of this rapidly developing crisis is action of the Selective Service System in abolishing occupational deferments for premedical and medical students not enrolled in medical schools by July 1, 1944, plus curtailment of the Army Specialized Training Program and refusal of the War and Navy Departments to reinstitute the procedure of placing premedical and medical students on an inactive reserve status.

Even an appeal to the President of the United States by officials of the American Medical Association failed to bring about any modification of the situation, the President having declined to intervene.

OHIO RESOLUTION TRANSMITTED

Following the 1944 Annual Meeting of the Ohio State Medical Association in Columbus, May 2, 3 and 4, a copy of a resolution adopted by the House of Delegates, requesting the Army, Navy and Selective Service to take steps to remove the causes for this threat to a continuing supply of physicians, was transmitted to officials of the War Department, Navy Department and Selective Service. These produced polite replies but no constructive action.

During recent weeks Congressman Miller of Missouri, introduced a bill into the Congress (H. R. 5128) which, if enacted, would correct the serious situation which has developed, by directing Selective Service to defer no less than 6,000 premedical and medical students and no less than 4,000 predental and dental students in each calendar year.

MUST APPEAL TO CONGRESS

All physicians have been urged by the American Medical Association to give their active support to the Miller Bill and to write, and have their patients and acquaintances write, to members of the Congress, urging support for the Miller Bill. It is anticipated that hearings on H. R. 5128 will be held by Congressional committees soon after August 1, when Congress will resume its work after a Summer recess.

The following article published in the July 8, 1944, issue of *The Journal of the American Medical Association*, presents the history of this serious situation and points out the crisis which may develop unless corrective action is taken through enactment of the Miller Bill or along similar lines:

EVERY Ohio physician should immediately get in touch with Ohio members of the Congress and urge them to actively support and vote for the Miller Bill (H. R. 5128) referred to in the accompanying article. A list of Ohio members of Congress will be found elsewhere in this article. Many Ohio Congressmen are at their homes now during the Summer recess of Congress. See YOUR Congressman personally on this important matter if you can; if you can not, write him, other Ohio Representatives and Ohio's two Senators.

PROGRAM HAS DETERIORATED

"In January, 1944, it seemed that civilian and military needs for doctors would be met reasonably satisfactorily by the arrangement in which the 55 per cent of entering medical school classes would be provided by the Army Specialized Training Program, 25 per cent by the Navy V-12 Program and 20 per cent from civilian sources. In the past six months this program has rapidly deteriorated. Today medical educators and the medical profession of the country refuse to accept the responsibility for the acute shortage of medical care which will threaten this country within a few years if current regulations and policies persist. The responsibility must rest with the armed forces, the Selective Service System, the President and the Congress of the United States.

"In February the Army drastically curtailed the Army Specialized Training Program and

has since renegotiated its contracts with medical schools to provide 28 per cent of the 1945 entering classes instead of 55 per cent, increasing to 47 per cent the numbers medical schools must obtain from civilian sources.

SELECTIVE SERVICE RULING

"In April the Selective Service System abolished all further occupational deferments of premedical and medical students not enrolled in medical schools by July 1, 1944. As a consequence, it was estimated that the entering classes of 1945 would be reduced 25 to 30 per cent.

"The threat to medical care entailed in these policies was pointed out to General Hershey, the Secretaries of War and the Navy, the President and others, with the suggestions that the situation could be met by (a) reinstitution of the inactive reserves by the Army and Navy, which functioned well for a year, and/or (b) an appropriate Selective Service adjustment, which was definitely a second best arrangement.

"The Army and Navy rejected the first alternative as an evasion of the Selective Service law, and the Selective Service System rejected the alternate proposal because of the acute need of the Army for young men. The needs for medical care were considered to be subordinate to the needs of the fighting forces.

A. M. A. ACTION

"Alarmed by these developments, the House of Delegates of the American Medical Association, on the recommendation of the Council on Medical Education and Hospitals of the American Medical Association, passed the following resolution at its opening session, June 12:

> "WHEREAS, The present policy of the Army and the Selective Service System in preventing the enrollment of a sufficient number of qualified medical students will inevitably result in an overall shortage of qualified physicians, with imminent danger to the health and well being of our citizens; therefore be it
>
> "RESOLVED, That it is imperative that immediate action be taken by the President or the Congress of the United States to correct the current drastic regulations, which result in a restriction of the number of students qualified to enter the courses of medical instruction in approved medical schools.

"This resolution was sent to the President, the Secretaries of War and the Navy, the Selective Service System and all members of the House and Senate Military Affairs committees.

NO FUNDS PROVIDED

"The latest measure still further jeopardizing medical education and medical care was the passage of the Army appropriation bill by Congress June 21. This bill includes the following provision:

"Provided That no appropriation contained in this Act shall be available for any expense incident to education of persons in medicine (including veterinary) or dentistry if any expense on account of this education in such subjects was not being defrayed out of appropriations for the military establishment for the fiscal year 1944 prior to June 7, 1944. . . .

"This provision would seem to eliminate from 1946 entering medical classes the 28 per cent of places contracted for by the Army. Even if the Navy increases its quota from 25 per cent to 31 per cent, schools will be obliged to obtain 69 per cent of their students from women and physically disqualified male students. Nothing even approaching this number of qualified civilian students is available. Classes will probably be half filled in the country at large.

DEFICIT OF 2,000 DOCTORS SEEN

"Should an adjustment not be made to correct the present alarming situation, a tremendous reduction of graduates after the war will ensue. Although schools will continue the accelerated program, they will admit classes only once annually instead of every nine months. This of itself will reduce the number of graduates from the present annual average of 7,000 to 5,000. If classes can be only half filled, this number will be reduced to 2,500 graduates per year. Since 3,300 to 3,500 physicians die each year, there will result an annual and cumulative deficit of 2,000 doctors a year.

"Still further reductions in graduates and permanent damage to the 'plant' of medical education will result from some schools being forced to close their doors because of drastically curtailed enrollments. An unknown number of war casualties among medical officers will also reduce the supply of physicians.

"These reductions in medical graduates will occur in the face of new and increased demands for medical services, mainly from the civilian population, the standing Army and Navy, the Veterans' Administration and the liberated countries of Europe.

TEXT OF MILLER BILL

"Full support should be forthcoming from the medical profession for the Miller Bill (H. R. 5128), with modifications, which reads:

> "Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 5 of the Selective Training and Service Act of 1940, as amended, is amended by inserting at the end thereof a new subsection reading as follows:
>
> "(n) There shall be deferred from training and service under this Act in the land and naval forces of the United States, as necessary to the maintenance of the national health, safety, and interest, in each calendar year not less than six thousand medical students and not less than four thousand dental students. As used

in this subsection the term 'medical or dental student' means (1) a person who is enrolled in, and who is pursuing a course of instruction prescribed for the degree of doctor of medicine at an accredited medical college; and a person who is enrolled in, and who is pursuing a course of instruction prescribed for the degree of doctor of dentistry at an accredited dental college; or (2) a person who is pursuing a regular course of instruction at an accredited college or university (satisfactory completion of which will make such person eligible for enrollment in an accredited medical or dental college) with the bona fide intention of entering an accredited medical or dental college and pursuing and completing the course of instruction prescribed for the degree of doctor of medicine or for the degree of doctor of dentistry."

WRITE THESE CONGRESSMEN IMMEDIATELY

PROTESTS against the present procedure which fails to protect medical and premedical students and communications urging support of the Miller Bill should be sent by Ohio physicians and their friends to the following members of Congress:

Senator Robert F. Reynolds, chairman, Senate Committee on Military Affairs

Rep. Andrew J. May, chairman, House Committee on Military Affairs

Senator Elbert D. Thomas, chairman, Senate Committee on Education and Labor

Rep. Graham A. Barden, chairman, House Committee on Education

Rep. Charles H. Elston, Cincinnati, member, House Committee on Military Affairs

Senator Harold H. Burton, Cleveland

Senator Robert A. Taft, Cincinnati

Rep. William E. Hess, Cincinnati

Rep. Harry P. Jeffrey, Dayton

Rep. Robert F. Jones, Lima

Rep. Cliff Clevenger, Bryan

Rep. E. O. McCowen, Wheelersburg

Rep. Clarence J. Brown, Blanchester

Rep. Frederick C. Smith, M. D., Marion

Rep. Homer A. Ramey, Toledo

Rep. Thomas A. Jenkins, Ironton

Rep. Walter E. Brehm, D.D.S., Logan

Rep. John M. Vorys, Columbus

Rep. Alvin F. Weichel, Sandusky

Rep. Ed. Rowe, Akron

Rep. P. W. Griffiths, Marietta

Rep. H. H. Carson, Canton

Rep. J. Harry McGregor, West Lafayette

Rep. Earl R. Lewis, St. Clairsville

Rep. Michael J. Kirwan, Youngstown

Rep. Michael A. Feighan, Cleveland

Rep. Robert Crosser, Cleveland

Rep. Frances P. Bolton, Lyndhurst

Rep. George H. Bender, Cleveland Heights

Boston Conference and Seminar on Medico-Legal Subjects Planned

The Massachusetts Medico-Legal Society in conjunction with the medico-legal departments of Harvard, Boston University and Tufts Medical Schools has arranged for an all-day conference to be held at the Mallory Institute of Pathology, Boston City Hospital on Wednesday, October 4, 1944.

It will include lectures, demonstrations, and informal discussions concerning many subjects in legal medicine, particularly stressing some of the more recent procedures. This meeting will be open to any registered physician, lawyer, police official, senior medical student or other medical investigator who may be interested and care to register. There will be no fee for registration. It would be helpful to those arranging the conference if notice of intention to attend be sent prior to October 1 to Dr. W. H. Watters, Department of Legal Medicine, Harvard Medical School, Boston.

The Harvard Medical School, Courses for Graduates, with the cooperation of the Medical Schools of Boston University and Tufts College will offer a seminar in legal medicine to occupy the entire week of October 2-7, inclusive. It is planned particularly for medical examiners and coroner physicians but will be open to any other suitable graduate of an approved medical school.

The course will consist of autopsy demonstrations, technique and interpretation of laboratory tests, study of the day-by-day cases of a medical examiner, round-table conferences, and the many subjects now included in the widening field of legal medicine. The enrollment has been limited to fifteen. For the seminar the fee is $25. Applications should be made on or before October 1 to Harvard Medical School, Courses for Graduates, 25 Shattuck Street, Boston 15, Massachusetts.

Ohio Physicans Elected

The following Ohio physicians were elected officers or delegates of sections at the recent annual meeting of the American Medical Association: Dr. Roy W. Scott, Cleveland, member of the executive committee, Section on Practice of Medicine; Dr. A. D. Ruedemann, Cleveland, alternate delegate, Section on Opthalmology; Dr. Joseph P. Evans, Cincinnati, alternate delegate, Section on Nervous and Mental Diseases; Dr. Clyde L. Cummer, Cleveland, chairman, Section on Dermatology and Syphilology; Dr. Theodore A. Willis, Cleveland, chairman, and Dr. J. A. Dickson, Cleveland, member, executive committee, Section on Orthopedic Surgery; Dr. U. V. Portmann, Cleveland, secretary, Section on Radiology.

Industrial Commission Disbursed $3,457,727 For Medical Services During 1943; Record Number of Claims Filed

THE Industrial Commission of Ohio disbursed $3,457,727.45 for medical services to injured Ohio workmen during 1943, according to a recent report of E. I. Evans, chief actuary. Included in that figure is a relatively small amount for dental services.

Other expenditures during the year included $1,801,325.00, hospital care and nursing; $130,-821.34, funeral expenses, and $97,001,18, court costs, a total of $5,486,874.97. These amounts include payments covering treatment of injured private and public employees, as well as similar costs on occupational diseases, and are in addition to death awards and compensation to injured workmen.

Comparative figures for 1942 were as follows: $4,243,069.09, medical services; $1,760,898.69, hospital care and nursing; $133,104.41, funeral expenses, and $86,661.34, court costs, a total of $6,223,733.53. The considerable decrease in 1943 of the amount disbursed for medical service is of no special significance, as a change by the Auditing Department of the Industrial Commission in the method of compiling records in 1942 resulted in the inclusion in the 1942 figure of approximately $800,000 of medical fees which had been allowed late in 1941, but were actually paid in 1942. The amount disbursed by the Commission for medical service during 1941 was $3,322,792.06.

RECORD NUMBER OF CLAIMS

The number of claims filed during 1943 was 331,072, a record for the 32-year history of the Ohio Workmen's Compensation Fund. There were 320,793 claims filed in 1942, the previous peak year. The total for 1932, during the depression, was 130,099.

"Medical only" claims, involving payment for physicians' services but no compensation to the claimant for loss of time, numbered 260,150 in 1943, or 78.6 per cent of all claims filed, compared with 80 per cent in 1942. The average fee of "medical only" claims increased from $7.69 in 1942 to $7.88 in 1943.

CONDITION OF THE FUND

Included with the actuary's report is a statement of the financial condition of the Ohio State Insurance Fund as of December 31, 1943. (Table 1). The surplus of the fund increased $3,078,-574.41 during the year, resulting in a surplus at the close of 1943 amounting to $10,949,870.91. The statutory surplus (to provide for catastrophic losses and other statutory contingencies) increased $247,648.62 to $3,821,437.77.

The total assets of the fund increased from $102,344,535.04 to $121,077,221.60, an increase of $18,732,686.56 during the year. The year's increase is the highest in the history of the fund, bringing the total assets to a new all-time peak.

An addition of $12,224,753.86 has been made in the amount of reserve set aside for future payment of benefits on claims occurring prior to 1944, this being an increase from $78,438,542.23 to $90,663,296.09. The report points out that it is expected that the fund will incur a greater benefit obligation due to the intensive activity of industry with increased employment. Further, it is recognized that many persons not ordinarily engaged in industrial employment are now actively employed and under the protection of the fund.

REDUCED RATES

Following are some important excerpts from the actuary's report for 1943:

"The Ohio State Insurance Fund has experienced a very favorable year during 1943, the premium income having increased in a greater proportion than the increase in claim obligations, which has made it possible to reduce the general level of workmen's compensation basic rates 10.3 per cent. Based on the premium volume for the past year, it is estimated that this reduction will result in premium savings to employers of $3,400,000 and should result in the greatest decline in premium that has been made in the last nine consecutive annual rate reductions. While the rate decrease in percentage equals the decrease of 1942 there should result a greater premium saving due to the current higher premium volume. The accumulated effect of the decreases in workmen's compensation rates has resulted in the current level of rates being 40 per cent below the rates of 1935 and within 4.2 per cent of the bottom level of rates in the year 1929. In comparing the current rate level with that of 1929 recognition must be made of the increase in benefits, such as the increase in the weekly maximum from $18.75 to $21.00, the maximum death award from 6,500 to 7,000, and other liberalization of benefits for accidents and industrial diseases.

"The continuing acceleration of industrial activity occasioning increased employee earnings with a lesser increase in cost of obligations makes it possible to reduce the premium charged to industry. The greater opportunity for highly remunerative employment markedly alleviates the need for compensation for loss of earnings in many cases where compensation would otherwise develop.

TABLE 1

OHIO STATE INSURANCE FUND

(Workmen's Compensation)

FINANCIAL STATEMENT AS OF DECEMBER 31, 1943

*PRIVATE FUND

ASSETS

BONDS AT AMORTIZED VALUES		$109,629,570.57
State Treasurer's Bond Balance	$114,580,662.66	
*Less Public Fund	6,684,020.44	
Par Value of bonds	$107,896,642.22	
Amortized value over par	1,732,928.35	
All bonds are in the custody of the State Treasurer and consist of obligations of the Federal Government and Ohio taxing districts		
CASH		7,515,706.46
(Deposited with State Treasurer as Custodian)		
State Treasurer's Balance	$7,981,292.18	
*Less Public Fund	465,585.72	
PREMIUMS IN COURSE OF COLLECTION		3,240,115.11
(Less reserve for delinquent accounts)		
INTEREST ACCRUED		691,829.46
TOTAL ASSETS		$121,077,221.60

*The Ohio State Insurance Fund is separated by statute into two funds. The Private Fund covers employers in private industry, while the Public Fund covers the State, municipalities and other taxing districts.

LIABILITIES

RESERVE FOR COMPENSATION AND MEDICAL BENEFITS	$90,663,296.09
To cover future payments on claims where the inception of the injury or disease was prior to January 1, 1944. Compensation and other benefits extend over periods of time and, in some cases, during the remainder of the life of a claimant.	
OUTSTANDING WARRANTS	1,528,500.45
Warrents issued which had not been presented for payment to the State Treasurer by December 31, 1943.	
UNEARNED PREMIUM	8,719,284.27
Portion of Advance premium paid for coverage beyond December 31, 1943.	
SECURITY FLUCTUATION RESERVE	5,394,832.11
To provide for possible depreciation of bond investments.	
STATUTORY SURPLUS	3,821,437.77
To provide for catastrophic losses and other statutory contingencies. (No reinsurance is carried to cover catastrophe hazard.)	
SURPLUS	10,949,870.91
To provide for general industrial trends and non-statutory contingencies.	
TOTAL LIABILITIES AND SURPLUS	$121,077,221.60

TABLE 2

COMPARATIVE INCOME, LOSSES AND EXPENSE

Year	Earned Premium	Losses Incurred	Minus Investment Earnings	Net Losses Incurred	% Losses to Premium	Expense
1939	$16,214,045	$15,930,752	$1,929,504	$14,001,248	86.4	$138,747
1940	18,124,819	19,380,332	1,881,310	17,499,022	96.5	143,935
1941	25,323,544	22,650,750	1,877,703	20,773,047	82.0	154,573
1942	32,264,595	31,835,609	2,189,318	29,646,291	91.9	158,923
1943	33,360,118	30,193,423	2,667,109	27,526,314	82.5	179,959

"The five year comparison of the premium income and losses (Table 2) discloses the extensive increase in earned premium and net losses incurred in recent years. The fact that the increase in losses has not kept pace with the earned premium made possible the annual rate reductions. The increase in the assets available for investment has increased the investment earnings; however, the reduction in interest yield on investments results in interest earnings not increasing to the extent of the increase in assets.

"The 82.5 per cent loss ratio to premium

closely approaches the favorable experience of 1941 when a similar rate reduction of 10.3 per cent was made. The expense items represent the portion of the premium extended for maintenance of the Division of Safety and Hygiene and for audits of the Fund, and does not include the general administrative expense of the Fund, amounting to $1,371,858.05, which is provided by legislative appropriation from the State General Revenue Fund.

CLAIM COST

"The average cost per claim on accident claims showed a decrease of 5 per cent during 1943, compensation cost decreasing 4 per cent and medical cost decreasing 8 per cent. The reduction in the average claim cost is due in no small measure to the great manpower demand and the opportunity for workmen to return to work while still disabled.

TABLE 3

1943 BENEFIT DISBURSEMENTS DISTRIBUTED TO YEAR OF ACCIDENT OCCURRENCE

(Excludes Occupational Disease and Public Fund)

Year of Accident Occurrence	Compensation	Medical Hospital and Other Costs	Total	Per Cent
1943	$ 4,532,066	$3,585,978	$ 8,118,044	44.7
1942	1,986,129	795,258	2,781,387	15.3
1941	1,335,916	277,870	1,613,786	8.9
1940	861,425	101,868	963,293	5.3
1939	543,567	59,463	603,030	3.3
1938	496,082	27,392	523,474	2.9
1937	593,219	29,738	622,957	3.4
1936	406,012	27,110	433,122	2.4
1935	270,289	41,541	311,830	1.7
1934	173,242	16,571	189,813	1.1
1912-1933	1,855,465	130,437	1,985,902	11.0
Total	$13,053,412	$5,093,226	$18,146,638	100.

"The foregoing table shows the extent to which current disbursements must be made for continuing claims in which the accident occurred many years earlier. The disbursements from the Fund made during the year 1943 spread back over twenty-nine years of the Fund's experience. There were some disbursements still being made in 1943 for claims on accidents that occurred as early as 1913, the second year of the Fund's operation. The claim reserve of $90,663,296.09 is set up to provide the funds from which payments will be made for benefits that continue over an extended period of years in the future.

"During the year $13,053,412, or 71.9 per cent, of the total benefit disbursements were paid to injured workers or their dependents as compensation for loss of wage earnings, while $5,093,226, or 28.1 per cent, of the total disbursements of $18,146,638 were paid for fees for services rendered to injured workers by attending physicians, nurses, hospitals, and for funeral and court costs.

"Only 44.7 per cent of the year's disbursements was for accidents occurring within the year and 11 per cent was paid on claims incurred ten or more years earlier.

OCCUPATIONAL DISEASE

"The occupational disease premium in 1943 had increased to provide for the increase in occupational disease benefits to such an extent as to permit a reduction of 1.8 per cent in occupational disease rates. The increase in occupational disease losses is particularly pronounced in industries where silicosis is prevalent due to dust exposure.

THIRTY-TWO YEAR RECORD

"On March 1, 1944 the Ohio State Insurance Fund reached its 32nd anniversary as a state-operated workmen's compensation carrier for Ohio employers.

"For the first year and ten months the Fund operated in competition with private insurance companies, and for the last 30 years has been operated as an exclusive state fund in that private insurance companies have been prohibited from writing workmen's compensation insurance in Ohio.

"The record as to the accomplishments of the Fund from March 1, 1912 to December 31, 1943 is as follows:

Employers insured	167,573	(a)
Premium collected	$427,960,455	
Benefits disbursed	$356,639,619	
Interest collected	$ 52,267,169	(b)
Claims filed	5,563,887	

"(a) Number of employers insured at some period or continuously over the 32 years.

"(b) Interest earned on Fund investments used to pay benefits, thus obviating the necessity for premium in like amount.

RECENT YEARS GROWTH

Year	Employers Insured	New Claims Filed	Assets
1933	42,824	131,145	$ 40,167,624
1936	47,861	204,194	51,375,040
1939	51,861	183,180	67,856,966
1942	62,583	320,793	108,362,992
1943	60,492	331,072	128,299,916

"Since 1933 the Fund has shown a consistent growth in new claims filed and total assets to an extent which has far surpassed all former records, while employers insured has declined through the recent war years.

"The number of new claims filed follows rather closely the intensity of industrial activity, while the total assets have increased at a greater ratio than claims filed as the assets are required to be not only ample to meet the increasing claims but also to provide for the increased level of benefits."

Digest of Some of the Important Actions Taken by House of Delegates of A.M.A. at Recent 1944 Session

THE House of Delegates of the American Medical Association in Chicago, June 12-15, outlined policies on the future course of medical practice, which are vitally important to every American physician. Resolutions from the floor and reports of officers, councils and committees covered most of the current problems confronting the medical profession, including better distribution of medical care; maintenance of a high quality of medical service and high standards of medical education; consolidation and coordination of federal public health activities; better representation of the viewpoint of the medical profession in Washington; and many other such topics.

The complete proceedings of the Chicago session were published in the June 24 and July 1 issues of *The Journal of the A.M.A.*, and a resume of the meeting appeared in the July issue of *The Ohio State Medical Journal.* Following are brief explanations of some of the more significant actions taken by the delegates:

THREAT TO SUPPLY OF MEDICAL STUDENTS CITED

On the recommendation of the Council on Medical Education and Hospitals, the following resolution was passed at the opening session and was one of the most important actions taken:

> "Whereas, The present policy of the Army and the Selective Service System in preventing the enrollment of a sufficient number of qualified medical students will inevitably result in an over-all shortage of qualified physicians, with imminent danger to the health and well-being of our citizens; therefore be it
>
> "Resolved, That it is imperative that immediate action be taken by the President or the Congress of the United States to correct the current drastic regulations, which result in a restriction of the number of students qualified to enter the courses of medical instruction in approved medical schools."

For complete details regarding this question and later developments, see special article in this issue, pages 755-757.

SUPPORT OF PUBLIC RELATIONS COUNCIL ADVOCATED

The House approved and commended the activities of the Council on Medical Service and Public Relations which was created at the 1943 meeting, and urged that the Board of Trustees give ample financial support to the Council "in order that its services may be extended and become more useful to the profession of medicine".

Included in the Council's report as approved by the House, was a revision of the platform of the American Medical Association. **The text of that platform is published in full elsewhere in this issue of The Journal.**

The Council announced that its Washington office, opened April 3, 1944, at 1835 Eve St., N. W., is under the direction of Dr. Joseph S. Lawrence, Executive Officer of the Medical Society of the State of New York, and for many years in charge of the legislative activities of that society. Dr. G. Lombard Kelly, secretary of the Council since January 1, on leave of absence as Dean of the University of Georgia Medical School, returned to his former post July 1. His successor has not yet been named.

ADMINISTRATION OF E.M.I.C. PROGRAM CRITICIZED

The program of the Federal Government for the Emergency Maternity and Infant Care of Wives and Children of Service Men was the subject of a number of resolutions and reports. While the intent and purpose of the program were approved, its administration by the Children's Bureau and method of payment were disapproved. The recommendation was made that full control and regulations of the program be placed completely in the public health department of each state.

POLICY OF ONE DEPARTMENT FOR HEALTH ACTIVITIES APPROVED

The House approved a bill now pending in Congress, introduced by Congressman Miller of Nebraska, which would transfer all government agencies dealing with health to the United States Public Health Service. It also reiterated the long established policy of the A.M.A. requesting the Congress to create a Department of Public Health, the head of which shall be a cabinet officer.

RESOLUTIONS TO REMOVE WEST AND FISHBEIN DEFEATED

Two resolutions introduced on behalf of the California delegation proposed that Dr. Olin West, Secretary and General Manager, be commended for his long and faithful service to the Association, and be appointed Secretary Emeritus for life; and that the Editor of *The Journal of the A.M.A.*, Dr. Morris Fishbein, be replaced. The resolution pertaining to Dr. West was rejected by the delegates by an overwhelming viva

Attention: All Medical Officers and Their Relatives! Here Is Method Adopted By Ohio To Provide Those In the Services With November Election Ballot

EVERY Ohio physician serving with the armed forces, at home or abroad, should consider it his duty to vote in the November election.

Under the provisions of a bill passed by the Ohio General Assembly in special session April 27, absentee voting by persons in the service is greatly facilitated. The procedure is simple.

A physician, who is a legal resident of Ohio, may make written application for an absentee ballot to his county board of elections, or a relative may make the application.

Under the law, applications may be made by "the spouse, father, mother, grandparent, father-in-law, mother-in-law, brother or sister of the whole blood or half blood, son, daughter, adopting parent, adopted child, step-parent, step-child, uncle, aunt, nephew or niece" of the voter.

The application need not be in any particular form. It should merely request an absentee ballot; state the branch of the service in which the applicant is serving, and specify the location of his legal residence in Ohio so that the clerk of the county board of elections can determine the precinct in which he is located.

Applications for "war ballots" can be made now. The ballots will be ready for mailing by the clerk of each county board of elections to the absentee voter on or after August 9. In order to be counted, such ballots must be received by the board by 12:00 noon on election day, November 7.

The Ohio law provides that the absentee voter in the service will have an opportunity to vote for national, state and local candidates. The Federal absentee voting law recently passed by the Congress permits the voter to write-in his choice only for Federal offices. It is not legal in Ohio, and therefore any votes cast under the Federal law will not be counted in Ohio.

Never has there been an election in this country of such vital importance to physicians, not only as citizens but as doctors. Issues are at stake which will affect the future course of their lives and those of their families. Ohio physicians with the armed forces can and should express their views through the ballot by using this simple method of absentee voting.

Ballots will be sent to applicants via air mail, so there will be ample time for them to be marked and returned by election day, November 7, if requested promptly.

voce vote. The proposal that Dr. Fishbein be replaced also was turned down, by a standing vote of 144-9.

In recommending the disapproval of the foregoing resolutions the Reference Committee on Executive Session made the following comment:

"Never before has American medicine been so neeedful as now of unity. The desire to extend the high quality of medical service to all the people at a reasonable cost is the objective sought by all of us. Your committee is convinced that this can be attained more certainly if physicians throughout the nation would give their loyalty and support to those selected by the House of Delegates as members of the Board of Trustees and to the representatives selected by the Board itself.

"Your committee commends the loyalty and the efficiency with which these officers have for many years served the Association in carrying out the policies established by the House of Delegates. Your committee would also com-

mend the Board of Trustees of the Association for its judgment and wisdom in the management of the affairs of the Association."

A resolution from the House of Delegates of the Idaho State Medical Association requesting that steps be taken to limit the activities of Dr. Fishbein to the editorship of *The Journal of the A.M.A.* was likewise rejected, and a resolution from the Michigan delegation suggesting changes in the corporate and organizational setup of the A.M.A. was returned to the Michigan State Medical Society for clarification and more specific recommendations.

OHIO PROPOSAL ON INSURANCE FORMS IS ADOPTED

The House approved a resolution introduced by the Ohio delegation directing the Board of Trustees to arrange for a series of conferences between representatives of the American Medical Association and representatives of private insurance carriers to develop a simplification and standardization of insurance forms which require information and statements from physicians.

MISCELLANEOUS ACTIONS OF SPECIAL INTEREST

Miscellaneous actions taken by the House of Delegates included: Approval of the establishment in the headquarters of the American Medical Association of a source of information on educa-

HAY FEVER
EXTRAORDINARY EFFECTIVE TREATMENT
for previously non-responsive patients

Designed for Practical Use by ALL Physicians in this Locality

Today's most effective treatment of Hay Fever is based upon testing with the correct selection of *local* pollens and fungi. Testing technic is simple. It takes but a few minutes to run through the Barry selection for your locality. A Barry Testing Kit may be obtained for your patient containing the specific irritants determined by accurate botanical studies and pollen counts.

TREATMENT: Skin test *reactions of the local pollens and fungi* and a brief history are all that are needed to institute a suitable treatment series with Barry products. This *specialized* service permits incorporation of *ALL* the proper irritants in the proportions that will give most satisfactory results. Each treatment set is "TAILOR-MADE" to meet your own patients' requirements at ordinary stock set cost.

Give your patients the benefit of a scientific treatment that is patterned after allergists' most successful methods.

WRITE TODAY for your Barry Testing Kit containing 20 local pollens and fungi. Complete set 50c.

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Ethical preparations of finest quality . . . pure, potent and rigidly standardized . . . advertised exclusively to the profession, and sold at consistently economical prices.

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Thiamine Hcl.	1 Mg.
Thiamine Hcl.	3 Mg.
Thiamine Hcl.	5 Mg.
Thiamine Hcl.	10 Mg.
Ascorbic Acid	25 Mg.
Ascorbic Acid	50 Mg.
Ascorbic Acid	100 Mg.
Riboflavin	1 Mg.
Riboflavin	5 Mg.
Niacin	20 Mg.
Niacin	50 Mg.
Niacin	100 Mg.
Niacinamide	20 Mg.
Niacinamide	50 Mg.
Niacinamide	100 Mg.

SOLUTIONS

Sol. Thiamine Hcl. Oral
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If Your Journal's Late . . .

Please be as patient and tolerant as possible if you do not receive your copy of *The Ohio State Medical Journal* as promptly as in the past. Shortage of labor in our print shop and the preference which Uncle Sam must give to first-class mail have combined to make it virtually impossible for us to get *The Journal* to all readers as early each month as desirable. Wait until the 15th day of the month before assuming your copy has gone astray. If you don't get it by that time, let us know and we will endeavor to supply a duplicate.—*The Editor.*

tional and professional opportunities for returning medical officers;

Continuation of plans for the development of postgraduate opportunities for physicians when they are released from the service;

Endorsement of the recommendation of the U. S. Office of Education that schools throughout the country provide, with the collaboration of suitable authorities, programs of health education for all secondary schools;

Approval of a general procedure for industrial health examination, presented by the Council on Industrial Health after consultation with representatives of the American Federation of Labor, the Congress of Industrial Organizations, the National Association of Manufacturers, the United States Chamber of Commerce, and the Joint Claims Committee of the Stock and Mutual Casualty Insurance Companies;

Recommendation to the Board of Trustees that a plan be prepared whereby students of approved medical schools may become student members of the American Medical Association;

Instructed the Council on Medical Education and Hospitals to take necessary steps to have each approved medical school give an adequate course in medical sociology, medical economics and medical ethics;

Expressed opposition to the unionization of hospital employees;

Authorized the Council on Medical Service and Public Relations to employ a director of medical prepayment insurance to assist in the development of voluntary insurance against the costs of hospital and medical care;

Reaffirmed the principles of relationships between hospitals and radiologists, pathologists and anesthetists established in 1939.

Cleveland—Dr. Howard Dittrick is a new trustee of the Cleveland Health Museum and Dr. Ralph M. Watkins is vice-chairman of the Advisory Council.

ACTIVITIES OF COUNTY SOCIETIES

PORTAGE

Two Portage County physicians with a total of 104 years' practice were honored Wednesday night, June 23, by the Portage County Medical Society at a dinner meeting at the Twin Lakes Country Club, Kent. Dr. L. W. Prichard, who has been practicing in Ravenna for 54 years, and Dr. J. H. Krape, Kent physician for 50 years, were cited at the meeting. In behalf of the society, Dr. B. H. Nichols presented Dr. Prichard with a desk lamp, and Dr. Krape, a lifetime fountain pen. Corsages were presented to Mrs. Prichard and Mrs. Krape. Dr. Howard Dittrick, Cleveland, gave an illustrated talk on the old hospitals of Spain. Dr. Dittrick is now compiling a history of the Portage County Medical Society, one of the oldest in the state—E. J. Widdecombe, M. D., Secretary.

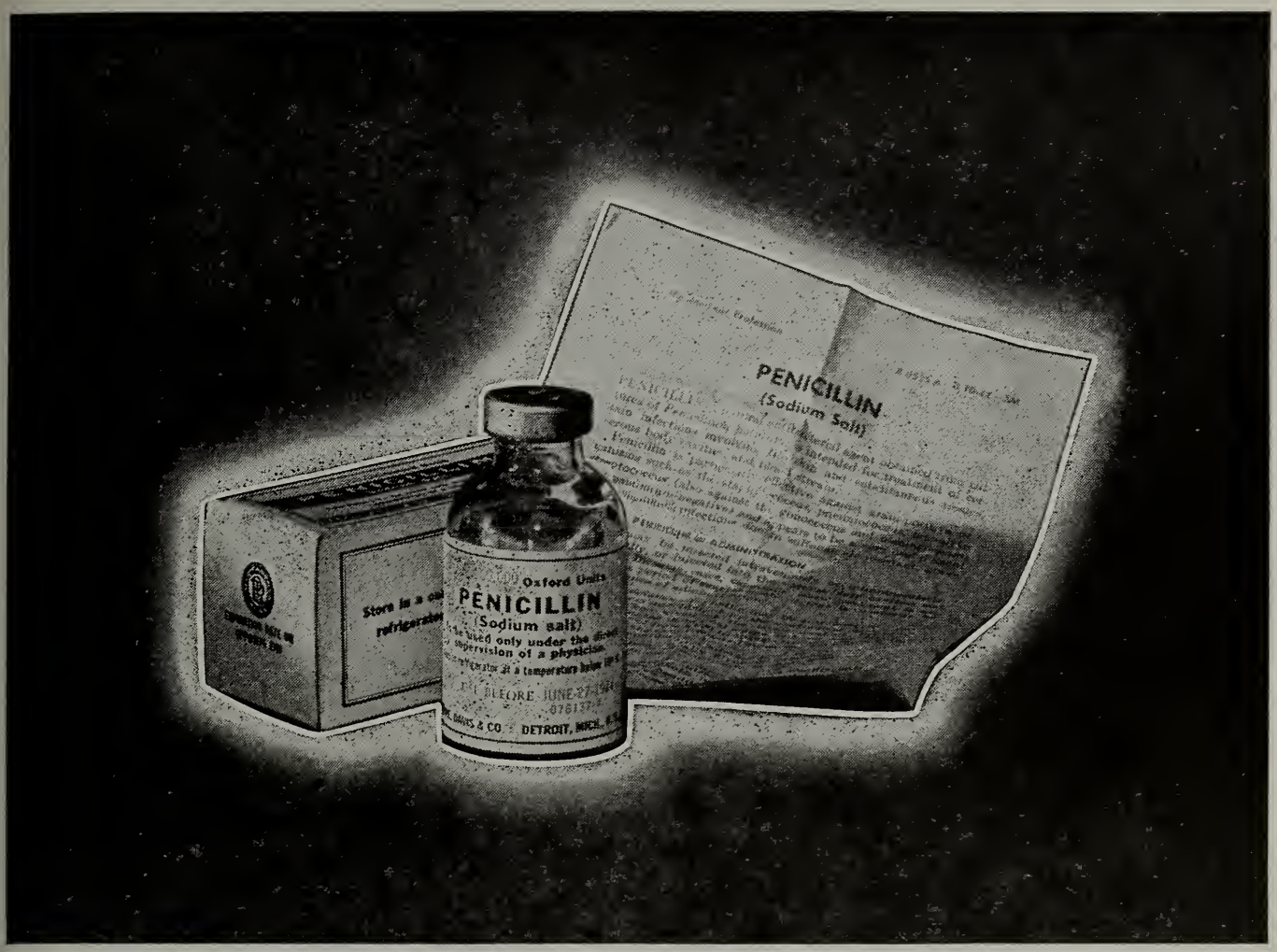
TUSCARAWAS

Members of the Tuscarawas County Medical Society and the Woman's Auxiliary attended a picnic July 13, at the home of Dr. and Mrs. Paul Hisrich, Bolivar. Following the supper, slides of old-time pictures were shown, and Dr. Burrell Russell, New Philadelphia, gave a report on the locations and activities of Tuscarawas County physicians now serving with the armed forces.—D. M. Ceramella, M. D., secretary.

WOMAN'S AUXILIARY NEWS

KNOX

Members of the Woman's Auxiliary to the Knox County Medical Society had a dinner meeting at the Mt. Vernon Country Club, June 14, with arrangements in charge of Mrs. O. W. Rapp, Mrs. Charles Baldwin and Mrs. E. V. Ackerman. The following new officers were elected: Mrs. John Drake, president; Mrs. Robert Eastman, president-elect; Mrs. Julius Shamansky, vice-president; Mrs. Richard Gomer, secretary-treasurer.



PENICILLIN

PARKE, DAVIS & COMPANY

When Parke, Davis & Co. began the commercial production of Penicillin in the summer of 1943, the world-wide output of this precious material was almost negligible. Today Penicillin has become a standard therapeutic agent—supplied in quantities needed for the Allied armed forces and for use in research and treatment of selected cases, and now increasingly available for use in civilian practice.

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Platform of A.M.A. On Improving the Distribution of Medical Care Revised at Recent Chicago Session

ONE of the most significant actions of the the House of Delegates of the American Medical Association at the recent meeting in Chicago was the unanimous approval of a supplemental report of the Council on Medical Service and Public Relations, revising and bringing up to date the platform of the A.M.A. adopted six years ago.

The original platform consisted of eight planks or principles, each followed by an explanatory statement. While the Council felt that these same principles still hold, with minor changes in their wording, it was pointed out that in some cases the explanatory matter had become obsolete, and neglected to cover some of the principles adopted by the House of Delegates since the original platform was approved. The Council also felt that there is one broad principle to which these eight principles are subservient. Hence, it was recommended that the platform be revised to read as follows and this recommendation was adopted by the House of Delegates:

THE PLATFORM

1. Availability of medical care of a high quality to every person in the United States.

In carrying out this widespread distribution of medical care and in any evolution necessary in the methods of administering medical care the basic principles necessary to the maintenance of scientific standards and the quality of the service rendered must be maintained.

It is not in the public interest that the removal of economic barriers to medical service should be utilized as a subterfuge to overturn the whole order of medical practice or the democratic plan of government. Removal of economic barriers should be an object in itself.

It is in the public interest that the standards of medical education be constantly raised, that medical research be constantly increased and that graduate and postgraduate medical education be energetically developed. Curative medicine, public health medicine, research medicine, and medical education all are indispensable factors in promoting the health, comfort and happiness of the nation.

In carrying out this objective, the A.M.A. advocates:

A. In the extension of medical services to all people, the utmost utilization of qualified medical and hospital facilities already established.

There is no evidence that the American people wish different doctors or a different system of medical care. There is evidence that they wish that care more widely distributed and they wish some method of easing its economic burden, especially by prepayment plans. That the people desire a personalization of service is evidenced by the fact that in the present time of full employment the turnover in charity hospitals is at a new low and the semi-private and private beds in the private and voluntary hospitals are overcrowded, whereas, in time of slack employment, the reverse is true.

The extension of hospital facilities should be carried out only after a careful survey which indicates that present hospital facilities are being used to the utmost or that there is a definite lack of hospital beds for a particular community.

Again, it has been argued that the demands for medical care in some sections of the country might require the importation of considerable numbers of physicians or the transportation of numbers of physicians in the areas in which they now are to other areas. In this connection it would seem to be obvious that a change in the economic status of the communities concerned would result promptly in the presence of physicians who might be seeking locations. The utilization of existing qualified facilities would be far more economical than any attempt to develop new facilities. There are many emergency situations which may arise in time of war. In most instances these emergencies will not continue after the war. Where they do other arrangements must be made to meet them.

B. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability, including the development and extension of voluntary hospital insurance and voluntary medical insurance.

In the United States today our sickness and death rates are lower than those of any other great country in the world. This fact is generally recognized. The medical profession recognizes the importance of doing everything possible to prevent every unnecessary death. At the same time it has not been established by any available evidence that a change in the system of medical practice which would substitute salaried government doctors for the private practitioner subject to the control of public officials would in any way lower sickness and death rates. Compulsory sickness insurance in no instance has given as good a health record as the American system.

The medical profession has approved prepayment plans to cover costs of hospitalization and also prepayment plans on a cash indemnity basis for meeting the costs of medical care. It continues, however, to feel that the development of the private practice of medicine which has taken place in this country has led to higher standards of medical practice and of medical service than are elsewhere and that the maintenance of that quality of the service is fundamental in any health program.

The American Medical Association has approved prepayment hospital insurance subject to the principles adopted by the House of Delegates. The number of people covered by it is

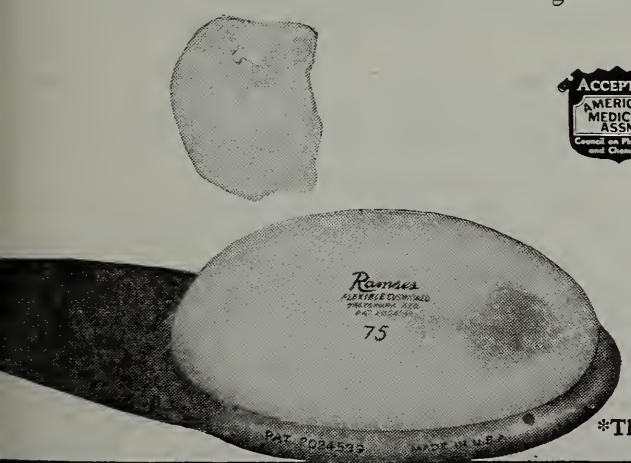


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The process used in manufacturing the "RAMSES"* Flexible Cushioned Diaphragm produces a dome which is soft and pliable and can best be described as being as smooth as velvet.

This velvet-smoothness lessens the possibility of irritation during use.

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constantly increasing. Its availability should be extended to all who desire it.

Medical expense insurance has developed slowly but much valuable experience has been accumulated. All constituent State Associations have been urged to develop voluntary plans within their territory so that the entire country may be covered by such plans. The A.M.A. will assist in the development, correlation and integration of such plans. State Welfare Departments should consider the use of the insurance principle in caring for the indigent and medically indigent, rather than the present system. Industrial medical care plans on the voluntary principle must be investigated and developed under the guidance of constituent associations and component societies.

C. Expansion of public health and medical services consistent with the American system of democracy.

Careful study of the history of the development of medical care in various nations of the world leads to the inevitable conclusion that the introduction of methods such as compulsory sickness insurance, state medicine and similar technics results in a trend toward communism or totalitarianism and away from democracy as the established form of government. The intensification of dependence of the individual on the state for the provision of the necessities of life tends to make the individual more and more the creature of the state rather than to make the state the servant of the citizen. Great leaders of American thought have repeatedly emphasized the fact that liberty is too great a price to pay for security.

D. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

The physicians of the United States have given freely of their time and of their funds for the care of the sick. Their contributions to free medical service amount to at least $1,000,000 a day. The physicians of this country have urged that every person needing medical care be provided with such care. They have urged also the allotment of funds for campaigns against maternal mortality, against venereal disease and for the investigation and control of cancer. The medical profession does not oppose appropriations by Congress of funds for medical purposes. It feels, however, that, in many instances, states have sought aid and appropriations for such functions without any actual need on the part of the state, in order to secure federal funds as might be available. It has also been impossible, under present technics, to meet actual needs which might exist in certain states with low per capita incomes, with needs far beyond those of wealthier states, in which vast sums are spent.

It is proposed here simply that Congress make available such funds as can be provided for health purposes; that these funds be administered jointly by the county, state, and federal health agencies, mentioned in Section H of this platform, and that the funds be allotted to proof of actual need to the federal health agency, when that need is for the prevention of disease for the promotion of health or for the care of the sick.

E. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

Obviously, if federal funds are made available to the individual states for the purpose mentioned in Section D of this platform, there might well be a lessened tendency in many communities to devote the community's funds for the purpose and, in effect, to demand that the Federal Government take over the problems of the care of the sick. Hence, it is suggested that communities do their utmost to meet such needs with funds locally available before bringing their needs to the federal health agency, and that the health agency determine whether or not the community has done its utmost to meet such needs before allotting federal funds for the purpose.

F. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

The medical profession wishes to extend preventive medical services to all people within the funds available for such a purpose. Obviously, this will require not only a federal health agency which may make suggestions and initiate plans, but also a mechanism in each community for the actual expansion of preventive medical service and for the proper expenditure of funds developed both locally and federally. In the development of new legislation, such mechanism may be suitably outlined.

So far as preventive medicine and general measures of public health are concerned, there is great need for the increase of county or district departments of health. There are still too many areas without such coverage. Every area in the United States should have a health service with adequate personnel and facilities to render the service necessary to each community. It should be integrated with and coordinated by the State Health Department. Federal funds may be used to help establish these departments where local funds are inadequate but the management should be under state and local authority.

G. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

The medical profession wishes to extend pre- other group in this country in its desire to extend medical care to all those unable to provide themselves with medical service. The American Medical Association has already recognized the existence of a group of persons able to provide themselves with the necessities of life commonly recognized as standard in their own communities but not capable of meeting a medical emergency. Hence, it is the platform of the American Medical Association that medical care be provided for the indigent and the medically indigent in every community but that local funds be first utilized and that local agencies determine the nature of the need and control the expenditure of such funds as may be developed either in the community or by the Federal Government, as they are the most capable of determining the needs.

TO PLACE MORE PENICILLIN

IN THE HANDS OF THOSE WHO NEED IT



PENICILLIN *Schenley*

WHEN the great need for Penicillin developed, it was natural that, with experience in the field of mycology and fermentation research, Schenley should turn its extensive facilities to this humanitarian cause.

The full-time services of our research staff were immediately applied to the task of perfecting a large-scale *Penicillin*-producing method. Progress was sufficiently successful to earn a place for Schenley among the 21 firms designated for production of the precious drug.

Today, *Penicillin* Schenley is augmenting the nation's supply of this valuable antibacterial agent. Our goal in these efforts is to aid in furnishing sufficient *Penicillin* to fill the fullest needs of both military and civilian medicine.

A RADIO PROGRAM DEDICATED TO AMERICA'S PHYSICIANS

"THE DOCTOR FIGHTS"
starring RAYMOND MASSEY

. . . a report to the nation on the widespread activities of America's doctors at war. We believe you will find this program of interest. Your suggestions or comments are welcomed.

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Emergency and migratory labor may be a temporary federal responsibility. The use of the voluntary insurance principle should be considered by all agencies distributing medical care.

H. The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government exclusive of those of the Army and Navy.

Today the medical and health functions of the United States are divided among a multiplicity of departments, bureaus and federal agencies. Thus, the United States Public Health Service and the Food and Drug Administration are in the Federal Security Agency; the Children's Bureau in the Department of Labor; the Veterans' Administration and many other medical functions are separate bureaus of the government.

Since 1875, the American Medical Association has urged the establishment of a single agency in the Federal Government under which all such functions could be correlated in the interest of efficiency, the avoidance of duplication and a saving of vast sums of money. Such a federal health agency, with a secretary in the cabinet, or a commission of five or seven members, including competent physicians, would be able to administer the medical and health affairs of the government with far more efficiency than is now done.

Gain in Life Span Recorded

The average life span of the American people had advanced in 1942 to 64.82 years, according to a recent statistical bulletin of the Metropolitan Life Insurance Company. This figure is the highest on record and represents a gain of 15½ years since 1900. The announcement points out that the retirement age of 65 will be attained by more than two-thirds of persons now between the ages of 25 and 35, by almost three-fourths of those now 35 and by four-fifths of those 55 years old. The average person 65 years of age has a life expectancy of 13.12 more years.

Named Officers of Special Societies

Among recently-elected officers of special societies are the following Ohio physicians: Dr. Edgar P. McNamee, Cleveland, vice president, American College of Radiology; Dr. Charles C. Higgins, Cleveland, secretary-treasurer, American Association of Genito-Urinary Surgeons; Dr. Charles L. Hartsock, Cleveland, vice president, American Therapeutic Society; Dr. Cecil Striker, Cincinnati, secretary, American Diabetes Association; Dr. Ralph G. Carothers, Cincinnati, president-elect, American Association for the Surgery of Trauma; Dr. Robert A. Kehoe, Cincinnati, president-elect, American Industrial Hygiene Association.

Changes in Regulations of American Board of Obstetrics and Gynecology

A number of changes in the regulations and requirements of the American Board of Obstetrics and Gyneocology were put into effect at the Board's last annual meeting. These were designed to aid civilians as well as candidates in the Service. Among these is the waiver, temporarily, of the AMA requirement for men in the Army or Navy, especially for those who proceeded directly or almost so from hospital services into Army or Navy Service, upon a statement of intention to join promptly upon return to civilian practice. At this meeting the Board decided also to accept a period of nine months as an academic year in satisfying our requirement for certain years of training. This is only for the duration and even men who are not eligible for military service but who are nevertheless in hospitals where the accelerated program is in effect have been allowed to submit to us this short-time period of training in lieu of our previous requirements.

Beginning with the next written examination, which is scheduled to be held the first Saturday afternoon in February, 1945, the Board will limit the written examination to a maximum period of three hours and in submitting case records at this time, all obstetrical reports which do not include measurements either by calipers and, as indicated, by acceptable X-ray pelvimetry, will be considered incomplete.

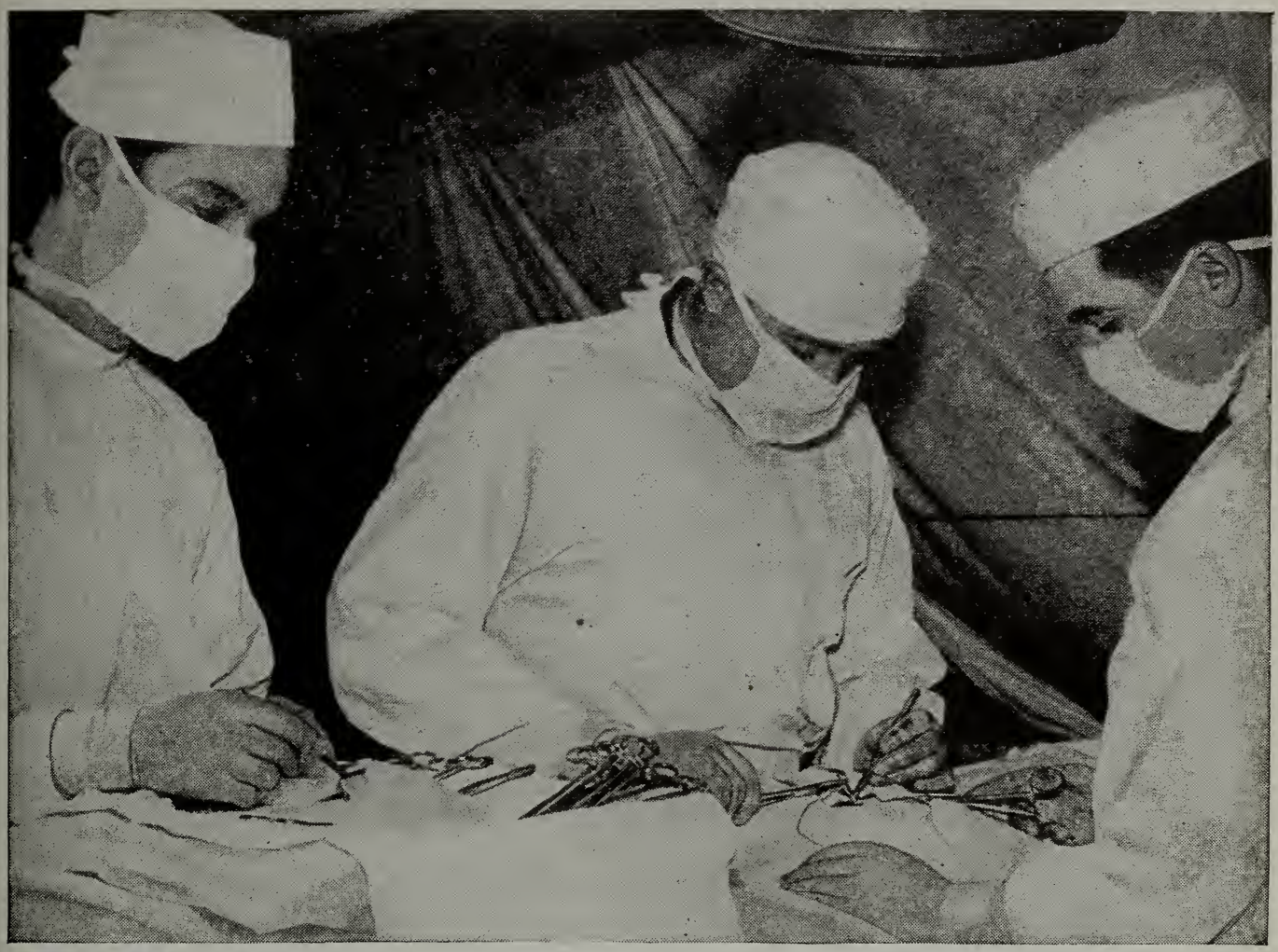
Applications and bulletin of detailed information regarding the Board requirements will be sent upon request to the Secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh 6, Pa. Applications must be in the Office of the Secretary by November 15, 1944, ninety days in advance of the examination date. The time and place of the Spring, 1945, (Part II) examination will be announced later.

Drs. Striker and Muhlberg Honored

At the recent annual meeting of the American Diabetes Association in Chicago, the Banting Memorial Medal was awarded to all ex-presidents and to all Banting lecturers of the Association. Recipients included: Dr. Cecil Striker, Cincinnati, a past-president, and Dr. William Muhlberg, Cincinnati, a lecturer.

The medal was created to memorialize Dr. Frederick Banting, who at the time of death was honorary president of the American Diabetes Association.

Columbus—"Soil Conservation, Nutrition and Human Health", was the topic discussed by Dr. Jonathan Forman at a meeting of the New Concord Women's Forum in Brown Chapel, Muskingum College.



War ...in white

Always exposed to enemy fire, bombing, the field clearing-station surgeons work under the worst hazards ever faced by "soldiers in white." Naturally, their brief respites . . . the occasional "breaks" for smokes . . . are delightful moments.

More delightful because their cigarette is likely to be a Camel... the milder, more flavorful brand favored in the armed forces.*

Today... as in the first world war... Camel is the "soldier's cigarette," every puff a cheering highlight in a fighting man's life.





1st in the Service

*With men in the Army, the Navy, the Marine Corps, and Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)

Camel COSTLIER TOBACCOS

New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y

Total of 2,827 Ohio Physicians Now in Various Services, Military Roster of State Association Shows

AFTER adjustments for additions to and separations from the services, the Military Roster of the Ohio State Medical Association totaled 2,827 on July 20. Of the total, 2,386 Ohio physicians listed are in the Army Medical Corps, 374 in the Navy Medical Corps, and 67 with miscellaneous services. Following are the names added to the Military Roster during the past month, those who were promoted, and a breakdown by counties:

NAMES ADDED TO MILITARY ROSTER

Name	City	Rank
Bortz, Donald W.	Cleveland	Lt. (j.g.) U.S.N.
Burkhart, S. E.	Cleveland	Lt. (j.g.) U.S.N.
Chambers, Wm. Robert	Cincinnati	Capt. U.S.A.
Clark, Charles	Columbus	1st Lt. U.S.A.
Deucher, Richard George	Cleveland	Capt. U.S.A.
Fisher, James D.	Cincinnati	1st Lt. U.S.A.
Fralick, Charles	Columbus	Lt. (j.g.) U.S.N.
Hilsinger, Elliott A.	Cincinnati	Passed Asst. Surg. U.S.P.H.S.
Inglis, Robert M.	Columbus	Lt. (j.g.) U.S.N.
Landes, John S.	Cleveland	1st Lt. U.S.A.
McCollam, Ben R.	Toledo	Lt. (j.g.) U.S.N.
Pfarrer, Richard	Dayton	Lt. U.S.N.
Scheib, Burton V.	Toledo	Lt. U.S.N.
Schneider, Richard V.	Toledo	Lt. U.S.N.
Schumaker, Leroy B.	Canton	1st Lt. U.S.A.
Wright, Norman S.	Springfield	1st Lt. U.S.A.

WIN PROMOTIONS

Name	City	Rank
Beare, Ralph J.	Celina	Surgeon U.S.P.H.S.
Boukalik, W. F.	Cleveland	Major U.S.A.
Craig, Robert M.	Dayton	Passed Asst. Surg. U.S.P.H.S.
Cremer, Albert E.	Lima	Lt. Col U.S.A.
Crile, George, Jr.	Cleveland	Lt. Comdr U.S.N.
DeWitt, Robert	Akron	Capt. U.S.A.
Engel, Wm. J.	Cleveland	Comdr. U.S.N.
Fitzgerald, Geo. P., Jr.	Springfield	Capt. U.S.A.
Frederick, Victor R.	Urbana	Capt. U.S.A.
Gledhill, J. M.	Warren	Capt., U.S.A.
Kaplan, Irwin	Cincinnati	Capt. U.S.A.
Langsam, Charles Lewis	Macedonia	Lt. Col. U.S.A.
LeFever, John D.	Springfield	Capt. U.S.A.
Lehrer, Henry G.	Wadsworth	Lt. U.S.N.
Malasky, Bernard S.	Cleveland Heights	Capt. U.S.A.
Merchant, Frederick T.	Marion	Major U.S.A.
Mielcarek, Paul A.	Cleveland	Major U.S.A.
Miller, Lawrence H.	Granville	Capt. U.S.A.
Minder, D. A.	Columbus	Major U.S.A.
Montgomery E. L.	Circleville	Major U.S.A.
Owen, J. M.	Dayton	Major U.S.A.
Root, Joseph C.	Cleveland	Comdr. U.S.N.
Ryan, E. J.	Cleveland	Lt. Comdr. U.S.N.
Ryan, James E.	Kelleys Island	Major U.S.A.
Sachs, E. W.	Dayton	Capt U.S.A.
Schwartz, Harold	Cleveland	Capt., U.S.A.
Schwemlein, Geo. X.	Cincinnati	Passed Asst. Surg. U.S.P.H.S.
Seymour, Miner W.	Columbus	Major U.S.A.
Shipley, Thomas	Canton	Capt. U.S.A.
Soloway, L. R.	Cleveland	Capt. U.S.A.
Uhl, Judd W.	Cincinnati	Capt. U.S.A.
Warner. C. F.	Cincinnati	Capt. U.S.A.
Weiss, Louis L.	Canton	Capt. U.S.A.
Wilkins, John M.	Marysville	Capt. U.S.A.

TABULATION BY COUNTIES

Adams 2	Guernsey 6	Muskingum .. 10
Allen 37	Hamilton 433	Noble 1
Ashland 12	Hancock 13	Ottawa 9
Ashtabula 17	Hardin 7	Paulding 2
Athens 11	Harrison 4	Perry 4
Auglaize 6	Henry 3	Pickaway 5
Belmont 14	Highland 8	Pike 2
Brown 4	Hocking 4	Portage 2
Butler 30	Holmes 2	Preble 7
Carroll 1	Huron 16	Putnam 6
Champaign ... 9	Jackson 1	Richland 38
Clark 33	Jefferson 28	Ross 24
Clermont 9	Knox 11	Sandusky 11
Clinton 8	Lake 18	Scioto 20
Columbiana .. 11	Lawrence 6	Seneca 12
Coshocton 4	Licking 17	Shelby 7
Crawford 9	Logan 8	Stark 98
Cuyahoga 684	Lorain 39	Summit 149
Darke 6	Lucas 160	Trumbull 27
Defiance 4	Madison 6	Tuscarawas .. 20
Delaware 7	Mahoning 118	Union 2
Erie 10	Marion 16	Van Wert.... 9
Fairfield 9	Medina 12	Vinton 2
Fayette 2	Meigs 3	Warren 4
Franklin 232	Mercer 6	Washington .. 8
Fulton 6	Miami 13	Wayne 14
Gallia 5	Monroe 1	Williams 8
Geauga 4	Montgomery ..151	Wood 18
Greene 6	Morgan 3	Wyandot 3

Total 2827

St. John's on Approved List

The Journal regrets that there was an error in the article on the report of the Council on Medical Education and Hospitals for the year 1943, which appeared on pages 460-466 of the May, 1944, issue. St. John's Hospital Cleveland, was included among the Ohio hospitals approved for residencies, but inadvertently omitted from the list of those approved for internship. St. John's also is approved for internship.

Coming Meetings

American Congress of Physical Therapy, Cleveland, Sept. 6-9.

Association of Military Surgeons of the United States, New York City, Nov. 2-4.

International College of Surgeons, United States Chapter, Philadelphia, Oct. 3-5.

Northwestern Ohio Medical Society, Findlay, Oct. 3.

Columbus—Dr. George M. Curtis, chairman, Department of Research Surgery, Ohio State University, gave the Leroy Long Memorial lecture at Oklahoma City, June 21, on "The Surgery of the Spleen". Dr. Long was formerly dean and professor of surgery, Oklahoma University Medical School.

Oberlin—Dr. Jeanne Stephens has been appointed acting health commissioner of Lorain County.



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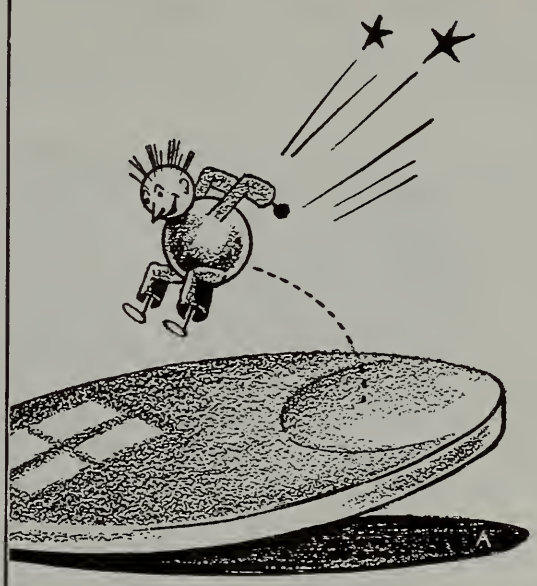
Iodine solutions, applied to the skin, continue their bactericidal action for several hours. This is important in surgery where it is desirable that a bactericidal barrier be maintained on the skin to minimize danger of pathogenic organisms from the air.

A further advantage of Iodine is the fact that it does not destroy normal leucocytic function.

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Providing Industrial Nurses With Written Standing Orders Is a Vital Responsibility of the Physician

LAST November the Committee on Industrial Health of the Ohio State Medical Association published in *The Ohio State Medical Journal* an outline, "Fundamentals in the Organization of an Industrial Health Program by a County Medical Society". The reception accorded this material and the interest it aroused have been gratifying. Hundreds of copies of the pamphlet have been distributed.

One chapter in this outline was entitled, "Legal Responsibilities and Limitations of Nurses and Lay Personnel". Coincident with the publication of this material, the Council on Industrial Health of the American Medical Association published a pamphlet, "Standing Orders for Nurses in Industry".

Numerous requests for the pamphlet on standing orders have been received both by the American Medical Association and the Ohio State Medical Association. It was reproduced in its entirety in the December, 1943, issue of *The Ohio State Medical Journal.* Discussions of standing orders for nurses have taken place at district meetings of industrial nurses and at their state meeting last May, demonstrating the interest which industrial nurses have taken and are taking in this subject. While some plants have had written standing orders for some time, numerous others have compiled them as a result of this new general interest in this subject.

EDITOR'S NOTE: The accompanying article on a very important phase of industrial medicine was prepared by the Committee on Industrial Health of the Ohio State Medical Association and is published under the sponsorship of that committee.

Each physician associated with the medical activities of an industrial concern should read it carefully and take an active interest in seeing that the principles and policies enumerated are put into effect in the plant, or plants, which he serves.

Sound procedures in industrial medicine will pay dividends to all concerned not only now but in the postwar period. The policy of general application of the procedure for written standing orders for nurses in industry should receive the support and encouragement of the medical profession, individually and collectively.

FUNCTION OF LICENSED PHYSICIAN

The Committee on Industrial Health of the Ohio State Medical Association wishes to emphasize by means of this article its approval of the policy of standing orders for nurses—orders written and signed by the physician or physicians in charge of the medical activities in all plants. Medical care is the function of the licensed physician, and the licensed physician only. This statement is the essence of the Ohio law. Therefore, those assisting in the medical activities of a plant must have direct supervision and guidance from a licensed physician.

It is conceded that most, if not all, civilian standards of service of all kinds have of necessity suffered during the war, either qualitatively or quantitatively. Qualitatively, industry has suffered through the depletion of so many skilled employes, but quantitatively industry's ranks have been swelled by hundreds of thousands due to the demands of war production. This has led to an increased demand for more medical service in industry. Consequently many more industrial nurses have been employed to meet new demands for nursing services as a part of the over-all medical program.

The medical profession on the other hand has suffered quantitatively. For example, more than one-third of Ohio's practicing physicians have entered the armed forces. Qualitatively, there has been no deterioration as the standards of medical education and the requirements for licensure have not been lowered.

In the older companies where medical service was already established and in many newer companies where judgment has been sound, nurses have been supplied with adequate medical supervision. In too many instances, however, nurses are expected to carry out their programs under lay supervision with little or no regard for the necessity of professional direction from a physician.

This situation has developed due to the stress of war. There is danger of its being carried over into the era of peace by the momentum of precedent. True, the letter of the law may be stretched many times under the stress of war but it should be returned to its normal stage when the stress of war disappears. The vital point is: If the spirit of the law becomes too distorted by the strain of emergency, this distortion may become a permanent disfigurement.

We know of no better method of emphasizing and maintaining sound fundamental principles



when apathy prolongs convalescence

Many convalescent patients, faced with the "drab succession of dreary days", may develop a reactive depression which can markedly retard normal recovery.

This depression may manifest itself in symptoms of apathy, hopelessness or despondency, psychomotor retardation and subjective weakness.

Obviously, the physician should guard against undue stimulation. But when, in his judgment, a convalescent patient will benefit by a sense of increased energy, mental alertness and capacity for work, the administration of Benzedrine Sulfate Tablets will often accomplish the desired result.

BENZEDRINE
SULFATE TABLETS
(racemic amphetamine sulfate)

As with any potent therapeutic agent, Benzedrine Sulfate should be administered under the supervision of the physician. Indications and contraindications are set forth in N.N.R.

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relating to the practice of medicine and the practice of nursing in industry than the perpetuation of the long and well-established practice which requires the nurse to carry on her duties under written orders of a licensed physician. In the hospital this policy has become so thoroughly established that the mere thought of its abandonment would be greeted with consternation. It has served to protect the patient, the doctor, the nurse and the hospital. Only insofar as this practice is adopted in industry will the employe, the doctor, the nurse and the management be protected.

NURSES DEMANDING GUIDANCE

The industrial nurses as a group have recognized the need for written standing orders and desire universal adoption of this procedure. Unfortunately there are no means by which the procedure for written standing orders can be simultaneously introduced into all industries. It is a step which must be taken individually by each plant with the approval and cooperation of lay representatives of management. If the nurse does not have the support of the physician in this demand for direction, her task becomes difficult, if not impossible.

The support of medical societies is not sufficient to help the nurse win medical supervision. Each physician must meet his individual responsibility. It is essential that the licensed physician most closely indentified with the medical activities in a plant give his support and assistance to the nurse or nurses employed by the plant. In other words, we emphatically recommend that each physician take a leading part in bringing about the establishment of a policy of written standing orders for nurses in all plants with which he has any connection. In the formation of sets of standing orders, the suggestions and assistance of the nurse can be of inestimable value because of her knowledge of special needs within the particular plant.

PROCEDURES WILL VARY

The type of written order which may be used in industry will vary somewhat from that usually supplied the hospital nurse, where the order in most instances is specific for an individual patient. In industry the requirements consist of standing orders describing procedures applicable to the situation most likely encountered. For that reason no one set of orders can be considered applicable to all industries in all communities. Individual variations will be desirable.

The "Standing Orders for Nurses" compiled by the Council on Industrial Health of the American Medical Association must be viewed in this light. They are not intended as a blanket mandate for all industries. They should be used as a general guide; tailored to fit the needs of the individual situation. It is likely that a collection of existing standing orders will be compiled in the near future. When and if this is done, there will be available a valuable collection of material for the physician who wishes to draw on the experience of others.

The Committee on Industrial Health of the Ohio State Medical Association takes this opportunity to reaffirm its belief in the necessity of written standing orders for nurses and offers its active assistance in perpetuating sound principles in this, as well as other phases of industrial medicine.

Ohio Population Less in 1943

According to the U. S. Bureau of the Census, Ohio had a slight decrease of .3 per cent in population between April 1, 1940 and July 1, 1943. Excluding members of the armed forces overseas, the estimated population for July 1, 1943 was 6,886,316 compared with 6,907,612 on April 1, 1940. Comparable figures for the entire United States were 133,942,410 in 1943 and 131,669,275 in 1940. The District of Columbia and 25 states had population gains, while 23 had decreases. California showed the biggest gain, 22.6 per cent, with a total population of 8,466,522. New York had the largest decrease, 4.6 per cent, with a total population July 1, 1943 of 12,858,203.

Dr. Lucy Stone Hertzog, Chardon, chairman of the Bureau of Public Health, Social Hygiene, Preventive and Industrial Medicine of the American Institute of Homeopathy, discussed the Wagner-Murray-Dingell Bill at the Institute's Centennial Meeting, June 25, at Atlantic City.

* * *

John R. Mannix, formerly executive director of Michigan Hospital Service, Detroit, is the new executive director of the Chicago Plan for Hospital Care.

* * *

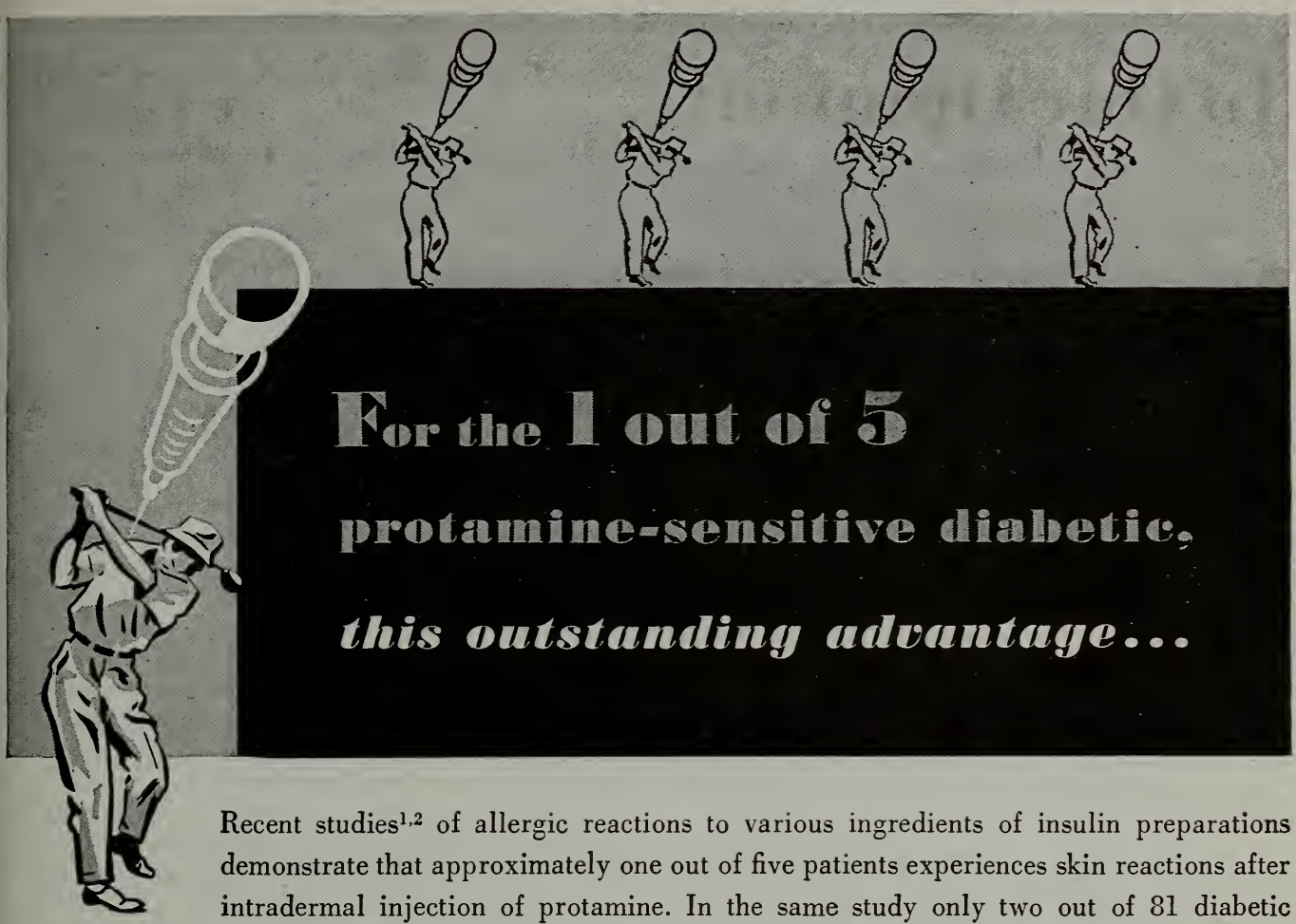
The program of the U. S. Public Health Service which provided federal assistance for the relocation of physicians and dentists in communities in need of their services, was terminated by Congress on June 30, 1944. The program became operative Dec. 23, 1943.

* * *

A total of 4,437 cases of typhus fever were reported in the United States during 1943.

* * *

Dr. Azel Ames, Hamilton, was recently elected to serve the unexpired term of the late Dr. H. Kennon Dunham, Cincinnati, on the executive committee of the Ohio Public Health Association.



For the 1 out of 5 protamine-sensitive diabetic, *this outstanding advantage...*

Recent studies[1,2] of allergic reactions to various ingredients of insulin preparations demonstrate that approximately one out of five patients experiences skin reactions after intradermal injection of protamine. In the same study only two out of 81 diabetic patients exhibited sensitivity following the intradermal injection of globin.

Bauman,[1-3] and Duncan,[4] as well as others, have reported that patients who suffered from severe skin reactions following the use of protamine zinc insulin obtained immediate relief upon changing to globin insulin with zinc.

WITH 'WELLCOME' GLOBIN INSULIN WITH ZINC, these other advantages:

A single injection daily of 'Wellcome' Globin Insulin with Zinc will control many moderately severe and severe cases of diabetes, helping to reconcile patients who resent more frequent injections. Timed to achieve morning onset of action and then maximum effectiveness during the afternoon, 'Wellcome' Globin Insulin with Zinc provides control during peak eating and working hours. Diminishing action after 16 hours allays the dread of "night shock".

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'Wellcome' Trademark Reg.

(1) Page, R. C., and Bauman, L.: J.A.M.A. **124**:704 (March 11) 1944. • (2) Bauman, L.: Bull. N. E. Med. Cen. V:17-21 (Feb.) 1943. • (3) Bauman, L.: Am. J. Med. Sc. **198**:475 (Oct.) 1939, ibid. **200**:299, 1940. • (4) Duncan, G. G., Diseases of Metabolism, Phila., Saunders Co., 1942, p. 782.

'WELLCOME' GLOBIN INSULIN WITH ZINC

Literature on request

BURROUGHS WELLCOME & CO. (U.S.A.) INC. 9-11 E. 41st St., New York 17

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

A SPECIAL MESSAGE TO DOCTORS IN THE SERVICES

It is vital that all Ohio physicians now in the services—in this country or abroad— cast their ballot in the General Election on November 7.

As citizens, each of you should be just as interested as those at home in seeing that well-qualified persons are elected to fill public offices. That is the obligation of every citizen.

As Americans, each of you should be just as interested as those at home in seeing that public offices are filled by persons who want to see the American principles of government preserved and will, by their acts, endeavor to guarantee in this country the freedoms which you are seeking to restore in other nations.

As physicians, each of you should be just as interested as physicians on the home front in seeing that public offices are filled by persons who believe that a revolution is not necessary to bring about improvements in the health of the American people; who believe that additional progress can be made through revitalized private enterprise, in cooperation, when and if necessary, with government but without the instigation of politically-controlled medical programs; who share the belief which most of you have that regimentation of the medical profession under a system of medical bureaucracy will produce only a minimum, sub-standard type of service; who will revolt at proposals which would destroy the incentives and opportunities that have been the keystones of American medicine.

One way which is open to you to express yourself on these and other important issues is participation in the November election.

The Ohio Legislature has amended the Ohio Election Laws to make it easy for you and other servicemen to vote by absentee ballot. The mechanics for obtaining an absent voter's ballot are described on page 762 of this issue. Reference to this also will be found in the June and July issues of *The Journal.*

Wherever you may be, as a citizen, an American, and a physician you should feel obligated to vote in this year's election—an election which may decide the destiny of your country for succeeding generations.

A SPECIAL MESSAGE TO DOCTORS ON THE HOME FRONT

The preceding "In Our Opinion" is directed especially to Ohio physicians in the services. This one contains a few suggestions on the same subject—voting in the November election—for those of you who are fighting the battles on the home front.

First: Are you registered to vote in the November 7 election? Are voting members of your family registered? How about your friends and neighbors? Better seek the advice of your Board of Elections on this immediately. Be sure to register and vote.

Second: What do you know about the candidates? Better find out something about them as soon as possible. The Legislative Committee of your County Medical Society will have pertinent information on them for you in the near future.

Third: Are you prepared to roll up your sleeves and work for votes for qualified candidates, especially those whose views on medical and health matters can not be doubted or questioned? Think this over. It's important.

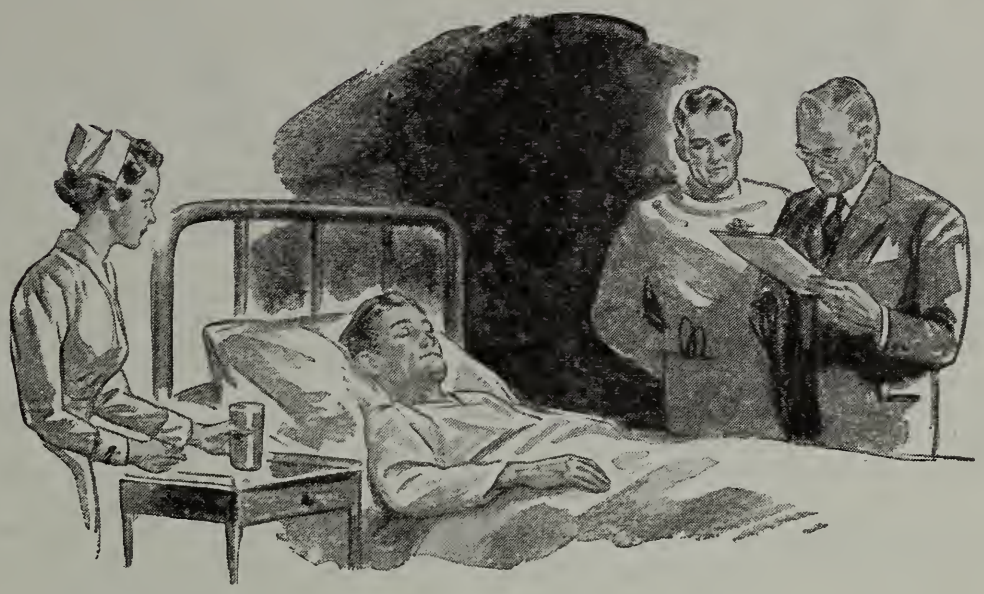
Americans still have the right to pick those who govern us and make our laws. Almost 3,000 Ohio physicians are directly engaged in the fight to restore that right to the citizens of many countries. It is the obligation of Americans to see that this right is maintained in America. The best way to see that this freedom is preserved is to take advantage of that privilege and inherent right; in addition, to take active interest in seeing that only qualified persons are placed in offices of public trust.

MR. MURRAY SUBMITS "MAGNA CHARTA" FOR BUSINESS

Business men who may feel they do not have a stake in seeing that the Wagner-Murray-Dingell Bill does not become a law and physicians who may feel they should not be concerned about some of the proposed legislation affecting business men, are badly disillusioned. Business men and doctors are all in the some boat, together with the general public, and to say the least the boat is being rocked badly at this time.

The Wagner-Murray-Dingell Bill has been pending in Congress for a year. During that time, efforts have been made by the medical profession to acquaint business men with the dangers and fallacies of that proposal. Now the shoe is on the other foot—business men are warning physicians of the dangers of a similar proposal, S. 1913, which would establish a virtual dictatorship of business generally.

Strange enough (or is it?) this so-called "Magna Charta for Small Business" also was introduced by Senator Murray—the Murray of the Wagner-



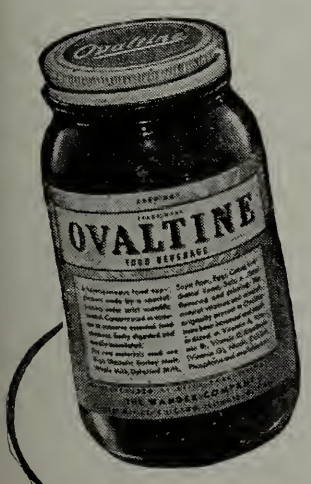
Proteins...Vitamins...Minerals

AS SOON AS LIQUIDS ARE RETAINED

The insult of anesthesia, tissue manipulation, unavoidable trauma, and enforced starvation sharply raise the nutritional requirements of the postoperative patient. Hence feeding must be started as early as possible to prevent too great a nutritional imbalance. Also, recovery is hastened and strength is gained more quickly when postoperative metabolic needs are supplied adequately.

Usually tolerated as early as liquids are retained, Ovaltine as a beverage provides a simple yet highly effective means of improving the nutritional state of the postsurgical patient. Its essential nutrients, well balanced and generously supplied, are in easily assimilated form. Thus the digestive burden is materially reduced. The delicious taste of this food drink proves appealing to all patients, young and old, making Ovaltine acceptable when many other foods are refused.

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Three daily servings (1½ oz.) of Ovaltine provide:

	Dry Ovaltine	Ovaltine with milk*		Dry Ovaltine	Ovaltine with milk*
PROTEIN	6.0 Gm.	31.2 Gm.	VITAMIN A	1500 I.U.	2953 I.U.
CARBOHYDRATE	30.0 Gm.	62.43 Gm.	VITAMIN D	405 I.U.	480 I.U.
FAT	2.8 Gm.	29.34 Gm.	THIAMINE	.9 mg.	1.296 mg.
CALCIUM	.25 Gm.	1.104 Gm.	RIBOFLAVIN	.25 mg.	1.278 mg.
PHOSPHORUS	.25 Gm.	.903 Gm.	NIACIN	3.0 mg.	5.0 mg.
IRON	10.5 mg.	11.94 mg.	COPPER	.5 mg.	.5 mg.

*Each serving made with 8 oz. of milk; based on average reported values for milk.

Murray-Dingell trio. It went into the U. S. Senate hopper on May 12, 1944, entitled: "To promote the more effective participation of all small business concerns in the war effort; to facilitate their successful adjustment to civilian and peacetime operations; to stimulate and encourage small business enterprise, etc".

According to the Conference of American Small Business Organizations with headquarters at 407 Dearborn Street, Chicago, (only a block away from the A.M.A. office in Chicago, coincidentally), this Murray bill:

Aims to be the panacea for all ills;

Aims to combine under one head and in the hands of one man "all powers, duties and functions prescribed and provided";

Sets up a vast government financial agency with a revolving fund of one billion dollars;

Would set up a business "advisor" in each of the 3,700 counties of the country.

Those who have studied the Wagner-Murray-Dingell Bill will note the similarity between these criticisms and some of the objections which have been raised concerning the Wagner-Murray-Dingell compulsory sickness proposal.

Begins to look as if the two Murray bills just didn't happen but are segments of an overall pattern which has been designed for postwar America and which is being backed by a concerted drive, sponsored by powerful groups, agencies and individuals who visualize a system of state socialism on a national level for the American people.

Those who favor putting an end to nonsense of this kind had better shake their lethargy with regard to political affairs and do something about keeping in the Congress, or electing to the Congress, men who will make short work of the Murray bills and their ilk.

APPEAL FOR FEDERAL HANDOUTS SHOULD CEASE

Year in and year out the medical profession has consistently protected encroachment on the part of the Federal Government in health and medical activities which are the functions of state and local governments and which should be administered and financed by them.

Many instances could be cited where federal handouts for medical and health programs have resulted in greater control and regimentation of these activities by Washington agencies, meaning more paternalism and bureaucracy, waste, inefficiency, and abuse.

Therefore, it is refreshing to learn that other groups are beginning to see the light and have become convinced that it is high time that a halt be called to the procedure, so popular during the depression years, of rushing to Washington on every occasion to get Uncle Sam to supply the wherewithal for things which are the responsibilities of local communities or the state.

We refer to the recent action of the Columbus Chamber of Commerce in urging business, individually and by groups, to "refrain, and use their influence to persuade others, including the state and local authorities, to refrain from exerting pressure upon members of Congress for the appropriation of funds for the benefit of individual states and local communities".

Comment on this action, the *Columbus Dispatch* said in part:

"Any proposal of federal aid to be acceptable, must rest on the very unsatisfactory and very shaky foundation of general weakness throughout the country. It is only when the nation is weak, frightened or uncertain that it will even consider the feasibility of substituting federal help for self help. That in the past few weeks the possibility of larger and larger grants of federal aid to communities for purposes of recreation, education, street building and repair, airport construction and the like have been suggested not only by theorists and reformers who would alter American life, but by many conservative business men comes as a distinct shock to even the most casual reader of American history.

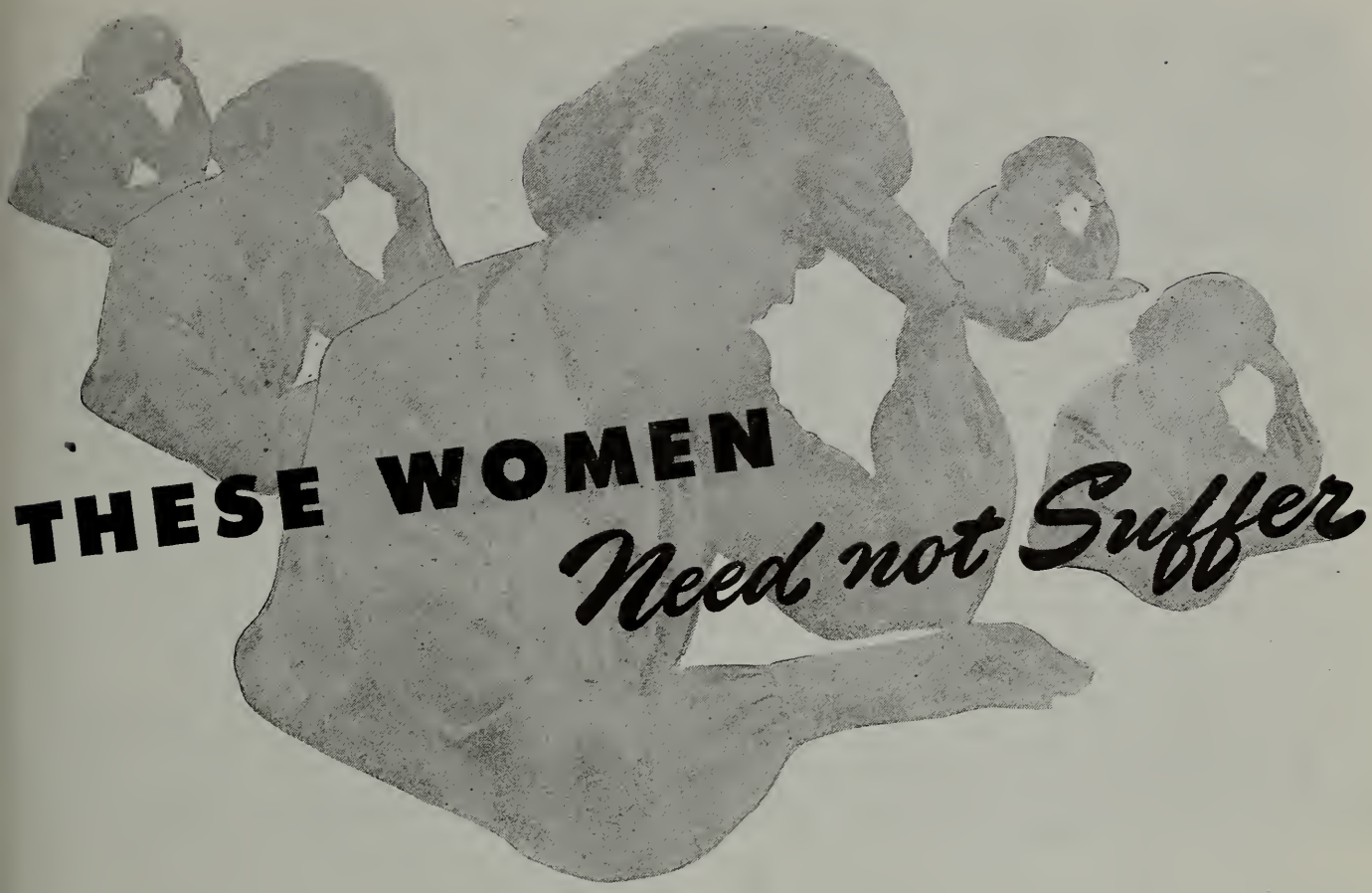
"Federal grants of money pave the way for federal regulations and control. The very restrictions which business is determined to get rid of after the war are those placed upon business because of the extension of federal money grants in the past. Certainly, the small business man, nor indeed, the large business man, can continue his production or his services if federal controls become any more numerous than they are.

"Ohio, for instance, with her prosperous cities and villages, counties and townships, needs no program of federal aid after the war.

"The Columbus Chamber of Commerce has taken a courageous and progressive stand on this matter.

"This should give our city councils, our township trustees, our county commissioners, our boards of education and our legislature solid backing in resisting what no doubt will some day be renewed pressure to ask for congressional appropriations for purely local use. It should help to maintain in this community at least, the spirit of local independence and self government, a spirit that is fundamental if America is to remain a sovereign union of sovereign states, and if the principle of home rule, under which the nation has become great, is to be kept vigorous and alive."

Physicians have witnessed what can happen in their field of endeavor when the Federal Government takes over—in some instances, we must admit, because local communities and the state have not been foresighted enough to meet their own responsibilities. As citizens of their community, physicians should use their influence against the issuance of appeals to Washington for handouts. If the snowball starts rolling again, there will be no escape for health and medical activities. Likewise, they should use their influence toward stimulating local enthusiasm for



FOR SOME WOMEN the climacteric is practically uneventful except for the cessation of menstrual function. To others the cessation of ovarian activity becomes a crisis to themselves and their families.

One of the valued contributions of endocrinology was the discovery and isolation of potent estrogens and their usefulness in alleviating the distressing symptoms of the menopause.

Within the last five years the natural estrogens have decreased in cost while orally administered diethylstilbestrol costing only one or two cents a day has brought estrogenic therapy within the reach of every woman.

The Squibb Laboratories supply the *natural* estrogens Amniotin, in a variety of dosage forms for use orally, intravaginally or by hypodermic injection. The present price of Amniotin in Oil in capsules is the lowest in history; for injection, Amniotin in Oil in the vial packages makes the cost per dose relatively inexpensive and enables the physician to vary the dosage to fit the patient's requirements.

Diethylstilbestrol Squibb is available in a like variety of dosage forms except that for oral administration it is supplied in tablets rather than capsules. Reports in the literature indicate that, where excessive dosage is avoided, many patients acquire a tolerance to the drug and are able to take it without discomfort.

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doing the jobs which should be done in all fields through the use of local funds, for in that way freedom of action and control of administration can be retained within the community.

PHYSICAL FITNESS PROGRAMS NEED MEDICAL GUIDANCE

Several times in these columns we have appealed to the medical profession to take a greater interest in the general question of physical fitness and recreation especially with regard to cooperating in and guiding present-day programs being sponsored by governmental agencies and the regular physical education program in the public schools.

The State Medical Association is working with the Ohio Department of Education and other organizations on such activities. At the request of this Association, about half of the county medical societies have organized committees for this particular purpose locally or have designated a standing committee to cooperate with local agencies interested in this field. Some societies have shown no interest. It behooves them to do so immediately.

American Medical Association representatives are actively cooperating with the National Committee on Physical Fitness of the Federal Security Agency in formulating a national program but, of course, this program will not click unless states and local communities make it a living project. The medical profession must lead and guide at all levels—national, state and local.

Congressional committees and certain governmental agencies are studying the figures on rejections under the Selective Service Act, almost 5,000,000 supposedly for physical disabilities. Undoubtedly, from these investigations will come new demands for programs designed to correct what appears to be physical weaknesses among a large number of the youths of the country. Such proposals may take the form of stronger agitation for subsidized medical and hospital services, programs to build more hospitals, expanded health education programs, extensive physical education and recreation activities, nutritional programs, etc.

In our opinion it is fallacious to draw alarming and generalized conclusions from the Selective Service figures. The physical requirements set by the armed forces are higher and more stringent than those used to determine whether or not an individual is capable of engaging in civilian activities. Nevertheless, the Selective Service figures do prove that steps to improve the health of the younger generation should be undertaken. Moreover, there is plenty of evidence indicating that organized programs in that direction will be forthcoming.

For that reason, it is high time that the medical profession in each community prepare to lead and guide in these activities. What group is better qualified to take that leadership? It is the responsibility of the medical profession to assume this leadership. If it does not, others will, which is certain to give control of important medical and health matters to those who are not sufficiently trained to handle such affairs competently.

Obviously, a lot of wild statements containing ridiculous conclusions will be issued by those who see in the Selective Service statistics an opportunity to get in additional plugs for governmental medicine. It will be up to the medical profession to meet the calamity howlers with analytical rebuttal. At the same time, however, it must do something tangible to promote those activities which are sound and proper. In other words, a rational approach must be made in Ohio and elsewhere toward the improvements needed and a lot of nonsense sidetracked.

Commenting on the need for medical guidance, *The Journal of the A.M.A.* on July 22 made the following pointed observations:

"While industrial programs of recreation and sports are built around mass action, their success is dependent on the correct diagnosis of the needs of each individual and the extent to which the individual embraces the opportunity to become fit. Particularly needed is an educational program directed along these lines.

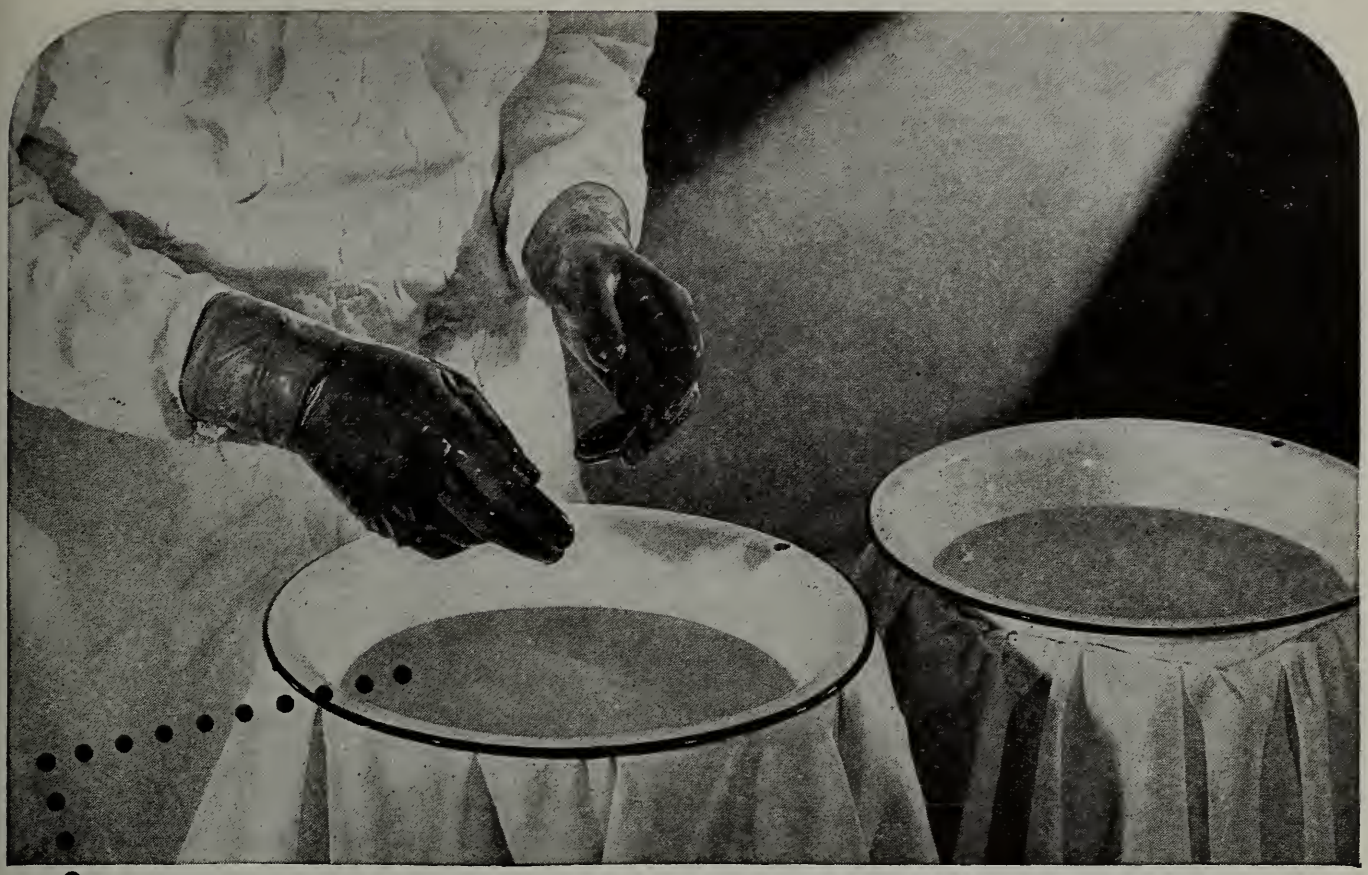
"A number of tests have been developed by medical science to determine physical fitness, particularly motor skills. In the development of such procedures Dr. J. Roswell Gallagher of Phillips Academy in Andover, Mass., and Dr. Lucien Brouha of the Hygiene Department of Harvard University have contributed greatly. They too emphasize the desirability of a body building program for every healthy person. They point out also that a proper physical education program requires more than calisthenics. The introduction of games and competitive sports which develop conditioning is an important part of the program for producing physical fitness. They too find that activities leading toward physical conditioning cannot be beneficial unless the person has been found medically fit and unless the program for physical fitness is planned to suit his needs."

Laymen are beginning to realize that medicine and the medical profession are important factors in physical fitness and recreation programs. This is revealed in the following excerpts from an article on this subject written by Whitney Martin, Associated Press writer:

"Just because a man is turned down by the examining physicians does not mean he hasn't taken care of his physical being and is suffering from lack of exercise, for some of our best athletes have been rejected.

"A program of exercise isn't going to fix a punctured eardrum or a popping knee for instance, and a great many men have been turned down for just such reasons—reasons that might be traced to violent physical exercise.

"Maybe a doctor could go in there with a



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soldering iron and fix up the eardrum, or do a little whittling on the knee, if the trouble was discovered in time, but the fact remains such rejections can't be blamed on the apathy of the rejected man toward exercise.

"The armed services are well-sprinkled with clerks and other more or less sedentary citizens who all their lives had a decided aversion to exercise in any form, smoked like chimneys, took a drink when they felt like it and otherwise lived on cushions.

"Yet they met the rigid requirements, while many of their exercising brothers have been turned down. For that reason it would be well to discover the percentage of rejectees who were turned down for reasons not related to exercise before becoming alarmed at the idea that we are a nation of pampered souls.

"We're all for exercise, and if a good plan can be worked out to give all youths at least a moderate dose of it we think it would be fine, although to say that all the kids benefit by it is another matter. We've seen too many college gym classes where a goodly number of the lads just went through the motions like robots. They had no taste for exercise whatsoever, and went to class just because they were required to, and with no thought of sprouting bulging muscles.

"Our service requirements are such that men are turned down who, for all practical purposes are able citizens in good health. Many have taken excellent care of themselves all their lives, but because of some defect which could be considered minor from the health standpoint they aren't acceptable to tote a gun. To say that these young men are soft and evidence of a decadent civilization is unfair, to say the least.

"Therefore, in forming a plan to insure a lower percentage of rejectees in the next war—heaven forbid—it might be a good idea to find out first how many youngsters really can be helped by exercise. As it is, some of our young men have been overexercised and banged around in sports until they aren't considered physically equal to their nonexercising brothers."

TRIBUTE BY THE PROFESSION TO DR. FOLLANSBEE

As a rule the reference committees of the House of Delegates of the American Medical Association, working at top speed in order to complete the large amount of work delegated to them, have little time or inclination to include personal references in their reports to the delegates.

For that reason, the report of the Reference Committee on Amendments to the Constitution and By-Laws, which was submitted to the House of Delegates at the recent 1944 session of the A.M.A., was of special significance in that it paid high tribute to Dr. Geo. Edw. Follansbee, Cleveland, chairman of the Judical Council of the A.M.A. as follows:

"At this time your committee wishes to take cognizance of the conscientious and perservering efforts of the Judicial Council under the brilliant leadership of the Chairman, Dr. Geo. Edw. Follansbee, who has devoted many years in establishing a Council which has faithfully and patiently helped solve many important problems. Dr. Follansbee's clear thinking and judicial attitude enhanced by his unquestionable loyalty to his organization sets an example for all of us. Your reference committee therefore takes this opportunity to express its deep appreciation of his untiring efforts. Futhermore, it is its sincere wish that we may continue to have the privilege from his wealth of experience and wise counsel."

Obviously, this appraisal of the ability and services of Dr. Follansbee is not news to his Ohio colleagues. They, long since, have recognized his unusual talents and have benefitted from his wise counsel during the years when he was active in an official capacity in the Cleveland Academy of Medicine and the Ohio State Medical Association. He is of that comparatively small group of physicians who took the lead in the activities of medical organization in Ohio at a time when medical organization was in need of a transfusion and therefore deserves a lion's share of the credit for having initiated projects and changes which have made the Ohio State Medical Association a going organization.

The significant thing about the well-deserved tribute paid to Dr. Follansbee by the American Medical Association in adopting the report of the reference committee is that it expresses the sentiments of the medical profession of the entire country, amplifying many times the feelings of the physicians of Ohio who have held him in such high esteem for a quarter of a century or more. Medical organization has progressed because of men like Dr. Follansbee.

DEMAND FOR PREPAID MEDICAL CARE INCREASING

To say there has not been an increasing demand for more ways for the public to finance medical care on a prepayment basis would deny the truth. It is a pretty well established fact that a large portion of the people want prepayment medical care plans of one sort or another. How it shall be done is a moot question. Two recent references to the question are indicative of the trend.

In its July roundup of Washington news, *Nation's Business*, publication of the U. S. Chamber of Commerce, offers this bit of enlightenment:

"Group health insurance plans are being developed aggressively by principal underwriters.

"Studies indicate employers may obtain complete health coverage for all workers and families (without medical exams), at an average cost of 1.5 to 2 cents per payroll hour (half usually paid by employee).

"Group health insurance—including doctors, hospitals, operations, accidents, maternity—presents potential 500 million dollars in new annual premiums, only one-fifth of which is now developed.

"Polls show workers prefer employer-sponsored plans to compulsory federal programs under Social Security."

One of the witnesses before a Senate sub-



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committee on health and education of which Senator Pepper, Florida, is chairman, was Vice Admiral Ross T. McIntire, surgeon general of the Navy and the President's personal physician.

Reporting his testimony before the committee, the Associated Press said:

". . . McIntire proposed today that the government provide health clinics to help build up a healthy postwar American youth . . . also advocated over-all medical and hospital insurance."

Continuing, the article stated:

"The part that the Federal Government can play in an over-all attempt to reduce the cost of medical care could well be applied to the providing of health clinics that would house laboratory, X-ray and special facilities that could be used by all of the doctors in the community, thereby reducing collateral cost to the patient," he said.

"His prepared testimony asserted that 'there are many ways in which the government could help' without bringing about what he termed 'the dreaded so-called socialized medicine'.

"While McIntire questioned whether compulsory medical care ever should be imposed certainly some form of health insurance, call it what you may, is necessary if the man in the low income bracket is to be able to procure adequate medical and hospital care for his family and himself. He suggested medical organizations be consulted as to methods."

NO BANDWAGON TOO HIGH FOR THEM

"There is a well-developed tendency on the part of many academic minds in government bureaus to hit upon a well-established fact and then dish it out as something new that would have remained undiscovered had it not been for the keen perception of these erudite gentlemen."

That is the reaction of Harry L. Sain, superintendent of the Division of Safety and Hygiene, Industrial Commission of Ohio, expressed in the *Ohio Industrial Commission Monitor*, to a report of the War Production Board which infers that mechanical safeguarding and safety equipment in industry were practically unknown until Pearl Harbor and were "discovered" by management under the prodding of federal agencies. As Mr. Sain points out, this obviously is not true as for years management—at least in Ohio—in cooperation with safety engineers and government agencies in Ohio has been aware of the importance of safety equipment, has encouraged its general use and has established sound safety programs in thousands of plants, big and little, in this state.

This is just another example of the attitude displayed by Washington bureaucrats that no bandwagon is too high for them to board and to take unto themselves the credit for a lot of things which were being done—and effectively—before their conception.

For example, long before the New Deal or the Social Security Act, Ohio had an efficient crippled children's program and a good maternal and child health program; it provided relief for the blind; and general public health services were carried on in a satisfactory manner. Now that the Federal Government has elbowed its way into these fields, Washington would like to have the public believe that it is the Moses which led the states out of the wilderness. True, the Federal Government has given valuable assistance. Frequently, it has gone too far. We recognize the good things which Washington has accomplished by aiding the states when assistance was indicated and necessary, but we, too, are fed up with the growing attitude on the part of federal agencies to take undeserved credit and to inject themselves into activities which are the responsibilities of each state and can be administered by existing departments of each state government.

As Mr. Sain curtly puts it: "The tendency to insinuate that the effectiveness of these measures is contemporary with the advent of the current political dynasty is, to say the least, somewhat tiresome."

Columbus—Dr. S. A. Hatfield has been appointed to a four-year term on the city board of health.

Ravenna—Medical science has reduced fatal casualties measurably in this war compared to World War I, Dr. John Painter, Kent, told members of the Kiwanis Club.

Middletown—"New Drugs and Treatments" was the subject of an address made by Dr. Ross A. Hill at a meeting of the Mother's Study League.

Tiffin—Dr. Mary T. Arnold Poling, wife of Capt. Carl Poling, now serving overseas, has been named acting health commissioner of Seneca County. A 1937 graduate of the University of Michigan Medical School, Dr. Poling was health commissioner of Jackson County, Ky., for several years prior to her marriage.

Portsmouth—Dr. C. L. Ferguson spoke to the members of the Kiwanis Club on the discovery, development and use of penicillin.

Amherst—A talk on the sulfa drugs and penicillin was made by Dr. F. E. Merritt at a meeting of the Rotary Club, of which he is president.

Columbus—Dr. Harry R. Burbacher has been appointed a trustee of the Columbus Public Library to serve the unexpired term of two years of the late Dr. Frank Warner.

Columbus—Dr. Blanche Montgomery Meyer spoke on "Developing Emotional Balance" at a meeting of the Women's Luncheon Club.

"... information on nutrition or other health subjects should be obtained from the medical profession . . ."

WATSON, E. R.: SYMPOSIUM ON NUTRITION,
J. MED. ASSN. GEORGIA, 32:326 (Oct.) 1943



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In Memoriam

Eli A. Fisher, M. D., Yorkshire; Medical College of Cincinnati, 1888; aged 80; member of the Ohio State Medical Association and Fellow of the American Medical Association; died June 28. Dr. Fisher, a former president of the Darke County Medical Society, practiced in Yorkshire for over 50 years. Surviving are his widow, a son, a daughter, a sister and a brother.

Adolphus William Foertmeyer, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1905; aged 65; member of the Ohio State Medical Association; Fellow of the American Medical Association; member of the American Psychiatric Association and the Central Neuropsychiatric Association; died June 24. Dr. Foertmeyer retired from private practice last January because of illness. A native of Cincinnati, he practiced there for over 30 years. During World War I he was in France as a major in the Medical Corps. Dr. Foertmeyer was a former assistiant professor of psychiatry at the University of Cincinnati College of Medicine. He was a Thirty-third degree Mason and a Shriner. His widow and an adopted son and daughter survive.

Frank Joseph Gallagher, M. D., Cleveland; University of Wooster, Medical Department, Cleveland, 1912; aged 56; former member of the Ohio State Medical Association, and former Fellow of the American Medical Association and the American College of Surgeons; died June 22, at Tucson, Ariz., to which he retired in 1933 because of ill health. Dr. Gallagher practiced in Cleveland for 21 years. He was a former chief of surgery and chief of staff of St. John's Hospital. Dr. Gallagher was an active member of St. Luke's Catholic Parish for many years. Surviving are his widow, three daughters, two sons, a sister and three brothers.

Lawrence Chamberlain Grosh, M. D., Toledo; University of Michigan Medical School, Ann Arbor, 1896; aged 74; member of the Ohio State Medical Association; Fellow of the American Medical Association; Diplomate of the American Board of Internal Medicine; died July 6. Chief of staff of Toledo Hospital until his retirement last year, Dr. Grosh practiced there for over 40 years. Intensely interested in medical research, Dr. Grosh was one of the key men in the drive to finance the building of a new Toledo Hospital in 1932, and later in the founding of the Institute for Medical Research. A letter man in football at Michigan, he maintained an interest in hunting and fishing and was a collector of guns. Much of his spare time was devoted to growing prize dahlias. Dr. Grosh was a member of Nu Sigma Nu and the Toledo Club. His widow and a daughter survive.

Germain B. Hale, M. D., West Liberty; Chicago Homeopathic Medical College, 1894; aged 72; died June 11. Dr. Hale practiced in Logan County for nearly 50 years. He was a Methodist and a Mason. Surviving are his widow a daughter, a brother, and two sisters.

Samuel Iglauer, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1898, aged 73; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; Diplomate of the American Board of Otolaryngology and the American Board of Plastic Surgery; member of the American Academy of Ophthalmology, American Laryngological, Rhinological and Otological Society, American Laryngological Association, and the American Broncho-Esophagological Association; died June 23. Prominent in his specialty, Dr. Iglauer was professor of otolaryngology at the University of Cincinnati College of Medicine, and a member of the staffs of General, Jewish and Children's Hospitals. He was a former president of the Cincinnati Academy of Medicine and has represented the Academy several times in the House of Delegates of the State Association. During World War I, Dr. Iglauer was a captain in the Medical Corps of the U. S. Army. In 1931 he was a member of the City Charter Commission. Dr. Iglauer was a member of Sigma Xi. Surviving are his widow and two daughters, one of whom is Dr. Helen I. Glueck.

Francis Ferdinand Kramer, M. D., Cincinnati; Medical College of Ohio, Cincinnati, 1905; aged 63; member of the Ohio State Medical Association and Fellow of the American Medical Association; died June 14. Dr. Kramer practiced in the Westwood community for nearly 39 years. During World War I, he was a lieutenant in the Medical Corps of the U. S. Army. A sister survives.

Nathan Vernon Noble, M. D., St. Marys; Ohio State University College of Medicine, Columbus, 1911; aged 55; member of the Ohio State Medical Association and Fellow of the American Medical Association; died June 26. Dr. Noble practiced in Auglaize County for over 30 years. One of his hobbies was trapshooting, for which he won many prizes. He was a life member of the American Trap Shooting Association. Dr. Noble was an officer in the Medical Corps of the U. S. Army during World War I. He was a member of the Methodist Church and the American Legion. Surviving are his widow;



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a daughter; two sons, one of whom, Dr. Vernon A. Noble, is a captain in the Army Medical Corps in England; two sisters; and five brothers, of whom three are physicians—Drs. Harry S. and Guy E. Noble, St. Marys, and Dr. Walter A. Noble, Lima.

Lovett E. Park, M. D., Columbus; Eclectic Medical College, Cincinnati, 1889; aged 82; died July 12. Dr. Park retired five years ago, after having been a member of the staff of Columbus State Hospital for 18 years. He previously practiced in Basil for 25 years. He was a member of the Presbyterian Church. His widow and a sister survive.

Lester Claude Pepper, M. D., Sidney; Starling Medical College, Columbus, 1898; aged 69; member of the Ohio State Medical Association and Fellow of the American Medical Association; died June 23. After practicing in Fort Loramie for a few years, Dr. Pepper opened an office in Dayton. In 1911 he located in Sidney. Actively interested in Republican politics, Dr. Pepper was a former member of the Shelby County Central and Executive committees, and legislative committeeman of the Shelby County Medical Society. He had also been president, vice-president, delegate and secretary of the society. Dr. Pepper was county coroner and examining physician for the local selective service board. He was exalted ruler of the local Elks Lodge four years ago, and prior to that time had been secretary for 20 years. Surviving are his widow, two daughters, four sons and a sister.

Marcellus Leroy Peterson, M. D., Cincinnati; Eclectic Medical College, 1899; aged 67; died June 15. A former lieutenant-colonel in the Medical Corps, Dr. Peterson resumed practice in Cincinnati after his retirement from the Army last October. He had previously practiced in the East End of Cincinnati for many years.

Rufus Southworth, M. D., Cincinnati; Miami Medical College, 1904; aged 66; former member of the Ohio State Medical Association and the American Medical Association; died June 15. Born in Southern France, Dr. Southworth began practice in Glendale in 1902, and later became professor of therapeutics at the University of Cincinnati until his retirement in 1931. During World War I he was in the Medical Corps of the U. S. Army. Following retirement as a teacher, Dr. Southworth was in Wu Hu, China, as a medical missionary. Returning to Cincinnati for a short time, he later left for the Pitcairn Islands where he gave medical care to the 200 natives and trained two young men to carry on his work. Dr. Southworth then made a trip around the world as ship's doctor on the yacht, Yankee, which was the basis for a number of articles and stories written by him. At the time of his death he was preparing a book for publication. A son, a daughter and three brothers survive.

Joseph Carlin Williamson, M. D., Columbus; Medical College of Ohio, Cincinnati, 1895; aged 70; member of the Ohio State Medical Association and Fellow of the American Medical Association; died July 5. Dr. Williamson practiced in Columbus for 38 years. His widow and two sons survive.

John Russell Woods, M. D., Ohio Medical University, Columbus, 1904; aged 63; died July 10. Dr. Woods practiced in Columbus for over 30 years. He was a member of the Masonic Order and an honorary member of the Daughters of America. Surviving are his widow and a sister.

Life Insurance Increases

Value of life insurance policies in the United States increased $8,700,000,000 during 1943, the Institute of Life Insurance reported recently. The institute said life insurance holdings have increased more than $14,000,000,000 since the war began, and that now 68,000,000 policyholders own an aggregate of $139,000,000,000 of life insurance. Investments of life insurance funds in industry supporting the war effort total $37,675,000,000, an increase of $5,000,000,000 since Pearl Harbor, the institute reported.

The wartime peak of 3,000,000 babies may drop to 2,100,000 after the war, Wilson H. Grabill, "fertility analyst" of the U. S. Bureau of the Census told a recent conference of statisticians.

* * *

Dr. Joseph T. Wearn and Dr. O. H. Robertson, Cleveland, were elected secretary and counselor, respectively, of the Association of American Physicians at its 78th annual meeting recently in Atlantic City.

* * *

The Advisor's Honor Key, with one star, has been awarded by the Grand Council of the Order of De Molay to Dr. Clarence W. Betzner, Cincinnati, for outstanding service on the Advisory Council of the Cincinnati chapter.

* * *

Dr. Robert S. Martin, Zanesville, was recently elected to the board of trustees of the National War Fund, Ohio Division, Inc., which represents 19 agencies in conducting fund-raising campaigns. They include U.S.O., War Prisoners' Aid, United Seamen's Service and Allied Relief agencies.

Luzier's National Patron Survey

A recent national survey, based on the answers to several thousand selection questionnaires taken from all of our sales divisions and districts, gives us the following information concerning the average Luzier patron:

The chances are 9/100 she is in her late 'teens; 34/100 she is between twenty and thirty; 29/100 she is between thirty and forty; 16/100 she is between forty and fifty; and 12/100 she is over fifty. Her average age is thirty-three. Her average weight, one-hundred and twenty-nine pounds. Her average height, five feet, four inches.

The chances are 62/100 she has a brunette complexion; 33/100 she has a blond complexion; and 5/100 she has a Titian complexion. The chances are 40/100 her skin coloring is fair; 33/100 it is olivaceous; 4/100 it is cream or ivory; 7/100 it is sallow; 3/100 it is extremely dark; 3/100 it is ruddy or florid; 1/100 it is pink; and 9/100 it is medium, i.e. neither light or dark.

The chances are 48/100 her skin, from a cosmetic viewpoint, is dry; 25/100 it is normal; 9/100 it is a combination type, i.e. dry cheeks with so-called oily inner circle—nose, chin, forehead; and 18/100 it is oily. The chances are 45/100 her skin is tender; 34/100 it is easily irritated.

The chances are 37/100 her eyes are blue; 33/100 they are brown; 15/100 they are hazel; 5/100 they are green; and 10/100 they are grey.

The chances are 54/100 her hair is some shade of brown, ranging from light to dark; 20/100 it is blond; 7/100 it is red; 9/100 it is black; and 10/100 it is grey or white. The chances are 32/100 her hair, from a cosmetic viewpoint, is dry; 45/100 it is normal; and 23/100 it is oily.

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WAR NOTES

"We've got the best damned medics in the world", said a Tiffin boy to a newspaper reporter at the Halloran General Hospital. Wounded on the Normandy beachhead, the G. I.'s great fear was that he'd lose his leg, but, he said, "They did a wonderful job on me". Other news stories and radio broadcasts are full of similar tributes. Medical officers are doing a fine public relations job for the profession.

* * *

News about Youngstown medics: Capt. J. M. Gledhill, chief surgeon with a hospital group now in New Guinea, previously in Australia; Lt. Benjamin G. Greene, whose itinerary with a field artillery outfit has been—New Zealand, New Caledonia, Guadalcanal, Russell Islands and Munda; Past Asst. Surgeon Harold Reese, U.S.P.H.S., Mobile, Ala.; Capt. C. M. Askue was on detached service at Station Hospital, Ft. Jackson, S. C., now headed overseas; Major L. S. Deitchman, with a general hospital in the ETO; Major C. W. Sears, returned from England because of illness; Major S. W. Weaver, chief of neurosurgery, Station Hosp., Santa Ana, Calif.; Lt. Col. W. D. McElroy, with a hospital unit in the Peninsular Base section of Italy.

* * *

Major R. R. Boice, Pomeroy, was home on leave recently, after over a year in Venezuela, where he was attached to the health and sanitation department of the Office of the Co-ordinator of Inter-American Affairs.

* * *

Major E. L. Montgomery, Circleville, who has been in the South Pacific with the 37th Division for over two years, was recently promoted to his present rank.

* * *

Major Walter A. Reese, Middletown, participated in a recent BBC broadcast from an air base in England, describing the air evacuation of wounded men from Normandy.

* * *

A news release from the Public Relations Office of the Headquarters of the United States Strategic Air Forces in Europe, written especially for *The Journal*, tells the following interesting story of the experiences of an Ohio medical officer who was in on the invasion:

An Eighth AAF Composite Station, Northern Ireland—Medical Surgeon on an LST (Landing Ship, Tank) in the first wave assault on the coast of France, Major Floyd A. McCammon, Van Wert, Ohio, has returned to this station because of a shoulder dislocation he received when he was flung from a ladder on the ship.

On Friday, June 10—the third day of the invasion—the Major was climbing down to the crew's quarters where the first casualties were being treated when a sudden lurch of the ship in the rough Channel flung him off the wet ladder, causing the injury.

"I didn't have time to think about my arm then", said Major McCammon. "One of the other doctors, a naval lieutenant, reduced the dislocation, taped it up, and we went on treating the casualties."

The assault boat the Major was on arrived at the French coast on Tuesday morning, but landing of troops and supplies was made hazardous by batteries of German 88's located in woods a few miles behind the beach. 'Jerry' pounded the beach with shell fire until U. S. aircraft knocked out the gun. After that, the Major says, the landing was accomplished with practically no opposition.

"They started bringing the wounded back on the first night," the Major stated. "We divided them into three groups—those needing immediate attention, those needing attention, and the men

It's a Serious Situation, Sir!

The War Notes' Editor is in difficulty! Since the deluge of mail acknowledging receipt of 1944 membership cards, letters from members in the service have fallen off considerably, and the source of "War Notes" has decreased accordingly. If he had the authority to issue a general order, he would do so, through proper channels, of course. It would be to the effect that all Ohio physicans serving in the armed forces are directed to communicate immediately with The Ohio State Medical Journal, 1005 Hartman Theater Bldg., Columbus 15, Ohio, stating, legibly, what they're up to (but not — why); comments on their assignments, accounts of unexpected "fancy seeing you here" meetings with other Ohioans, and any other news that is censor-proof. Granted that you are busy, sirs, but your colleagues in the service and at home are wondering where you are and what you're doing. So, how's for taking time to write us a line or two, so as the War Notes section can keep rolling?

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who could go for a few hours without attention. The crew gave up their quarters and we improvised a hospital there to take care of the wounded men. The more serious cases were transferred to a hospital ship that made a trip back and forth across the Channel every day."

"We were forced", McCammon continued, to perform major operations and amputations on board ship. The men stood up to it wonderfully. There was no complaining at all. As you might have guessed, blood plasma and penicillin played a big part in saving lives."

"From what I could observe", Major McCammon said, "the spirit of the troops participating in the assault was superb. Coming over, they were cheerful, and they ate well. Some started song fests and some just slept. They all were restless for the action to begin and completely confident of victory."

* * *

The Bronze Star Medal for meritorious service while in action with the 37th Division in the South Pacific has been awarded to the following Ohio medical officers: Lieut. Col. John C. Blinn, New Philadelphia; Lt. Col. Robert L. Mikesell, West Liberty, and Major Thomas V. Kolb, South Charleston.

* * *

Lt. Col. Walter K. Gregg, Dayton, who has been on active duty for three and a half years, is assistant director of Medical Technical Instructors, Division of the Medical Training Section, ASFTC, Ft. Lewis, Wash. After nine months at Camp Lee, Va., and 31 months at Camp Barkeley, Texas, Dr. Gregg is enjoying the Northwest, "though he is very, very busy".

* * *

Major Alfred W. Pinkerton, Lima, is chief of medical service of the 123rd Station Hosp., Camp Chaffee, Ark. He was previously assistant chief of medical service at the Army and Navy General Hosp., Hot Springs, Ark.

* * *

From China, writes Capt. S. W. Kessler, Cleveland: "Yes, The Ohio State Medical Journal reaches these parts and we of course appreciate it very much. Have run across a group of Ohioans here and in my travels, and our thoughts and conversations are largely about home."

* * *

News about Dayton medical officers, from the monthly newsletter of the Montgomery County Medical Society to members in the service: Capt. J. D. Apple, home on leave from Trinidad and Panama, married May 20, to Miss Betty Keohane, R. N., St. Elizabeth Hospital, Dayton . . . Major Paul Troup, home on leave from Bougainville, married June 21, to Miss Mary Jane Dunn, Steubenville . . . Capt. Reed C. Prugh, recently promoted, in the Gilbert Islands . . . Major W. R. Althoff, executive officer of medical battalion in the infantry division which spearheaded the attack on Cherbourg. Previously in action with the Ninth Division in French Morocco, Algiers, Tunisia and Sicily . . . Lt. Col. Roy D. Arn and Major Richard Hochwalt, with hospital units in Australia . . .Major J. K. Hoerner, chief of obstetrics and gynecology at 3,500-bed McCloskey General Hospital, Temple, Texas. Bulk of his patients, WACs, nurses and dependents of military personnel . . . Lt. Comdr. L. B. Hurless, chief of G. U., Naval Hospital, Oceanside, California, recently had a breeze session with Drs. Walter Simpson, Paul Yordy, and W. Taggart at the Long Beach Naval Hospital . . . Capt. B. Stuhlman, "keeping the pilots in the air and the ground crew healthy" in a fighter squadron in England . . . Capt. Homer P. Howell, Hamilton Field, Calif., doing consultation work in ophthalmology for the Air Force in northern California . . . Major E. F. Damstra, chief of the general surgical section with a general hospital unit in England . . . Major L. Papp, former Dayton acquaintance, in charge of the X-ray dept. . . . Since returning from the South Pacific, Comdr. Abe Cline is taking care of Navy dependents in the Chicago area . . . Capt. F. V. Grice, en route to Calcutta, India, unexpectedly bumped into his son, Jimmy, on the street in Casa Blanca. Hadn't seen each other for a year . . . Capt. Charles Wine, with a signal bn. in North Ireland has seen Dr. John Torrence there . . . Comdr. Paul Yordy, head of department of anesthesia at the U. S. Naval Hospital, San Diego.

* * *

Now in India with a general hospital unit, Capt. Geo. B. Watson, Columbus, has been around a good bit during his two years of Army service. His other assignments outside the continental boundaries of the United States, have been in Alaska and Africa.

* * *

Major Carr E. Dix, Columbus, with a station hospital in North Africa since November, 1942, is now on the orthopedic staff of a general hospital unit in Italy.

* * *

Capt. Louis L. Weiss, Canton, recently promoted, writes that he enjoys *The Journal*, received regularly where he is stationed at a base dispensary in Hawaii.

* * *

Recent changes of station within the United States: Capt. R. L. Weissinger, Sidney, Municipal Air Port, Memphis, Tenn.; Major Thos. D. Santurello, Columbus, Army General Hosp., Galesburg, Ill.; Capt. A. B. Schneider, Jr., Cleveland, School of Aviation Medicine, Randolph Field, Texas; Col. Scott C. Runnels, Cleveland, Veterans' Administration, Los Angeles, Calif.; Capt. D. J. Rehbock, Cleveland, Yakima, Wash.; Capt. B. H. Preston, Cincinnati, Sta.



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Hosp., Camp Howze, Texas; Major Paul A. Mielcarek, Cleveland, 124th Eva. Hosp., Camp Rucker, Ala.; Lt. R. W. Martz, Hamilton, Stout Field, Ind.; Capt. S. Albert Molle, Toledo, Newton D. Baker Gen. Hosp., Martinsburg, W. Va.; Capt. Bernard S. Malasky, Cleveland, FAAF, Florence, S.C.; Lt. Thos. E. Miller, Ironton, School of Aviation Medicine, Randolph, Texas; Lt. Col. John E. L. Keyes, Youngstown, ASFTC, Ft. Lewis, Wash.; Comdr. Roscoe J. Kennedy, Cleveland, USNTC, Great Lakes, Ill.; Capt. N. R. Krupkin, Cleveland, Army Medical Center, Walter Reed Hosp., Washington, D. C.; Lt. Comdr. R. D. Hildebrand, Newcomerstown, Armed Guard Center Pacific, San Francisco; Lt. Jas. A. Gavin, East Cleveland, AAB, Maxton, N.C.; Col. Howard C. Eddy, Cleveland, Desert Maneuvers, Camp Cooke, Calif.; Capt. Lloyd L. Dowell, 314th Med. Bn., Camp Butner, N.C.; Lt. (jg) S. E. Burkhart, Cleveland, U.S.N.T.S., Hunter College, The Bronx, New York; Capt. Henry A. Brunsting, Toledo, Harmon Gen. Hosp., Longview, Texas; Lt. Harry W. Burnett, Jr., Dayton, 119th Gen. Hosp., Camp Ellis, Ill.; Capt. Walter J. Brown, Conneaut, Regional Hosp. No. 2, Ft. Bragg, N.C.; Capt. Antonio S. Broglio, Cleveland, 123rd Gen. Hosp., Camp Ellis, Ill.; Capt. Samuel Hantman, Cleveland, Basic Training Center, No. 10, Greensboro, N.C.

* * *

Lt. Col. Hardy A. Kemp, on military leave from his post as Dean of the Ohio State University College of Medicine, is the new Secretary of the Army Medical Center, Washington, D. C. He recently returned from two years' overseas service, which included duty as assistant medical director of the Trinidad Engineering District in the West Indies, assistant surgeon of the U. S. Armed Forces in Central Africa, Medical Inspector of the China-Burma-India theater, and most recently Deputy Theater Surgeon of that area.

* * *

Lt. (j.g.) William E. Sovik, Youngstown, has been overseas since the middle of May "doing the routine work to which all doctors on LST's are assigned in the E.T.O.".

* * *

On the staff of the 1st Aux. Surg. Group, "over there", are Major James E. Ryan, Kelleys Island, Erie County, and Capt. Foster M. Williams, Cincinnati.

* * *

Lt. Col. Charles L. Langsam, Macedonia, is chief of medical service at the AAF, Fourth Service Command, Station Hosp., Camp Davis, N. C., where he has been stationed for nearly 3½ years. Major Robert D. Arthur, Springfield, is also on duty there. Dr. Langsam recently passed the examination of the American Board of Psychiatry.

* * *

The many friends of Dr. and Mrs. C. W. Kirkland, Bellaire, will regret to hear that their son, 1st. Lieut. Elmer Jebb Kirkland, a pilot in the Army Air Forces was killed in action over Biak on May 29. Dr. Kirkland is a former member of The Council of the State Association.

* * *

Major Edward A. Gall, Cincinnati and Major Paul R. McConnell, Youngstown, are on the staff of the Mayo General Hospital, Galesburg, Ill., which was formally dedicated on July 10.

* * *

At the recent war session of the American College of Physicians, Brig. Gen. Hugh J. Morgan, chief consultant in medicine, Office of the Surgeon General, stated that the death rate from pneumonia in the armed forces is .7 of one per cent, compared to 28 per cent in World War I.

* * *

Major Harry S. Tucker, who went to the Southwest Pacific in March, 1942, has been visiting his family in Cleveland. He was in command of the first American hospital train in Australia, and later commanded a portable surgical unit on New Britain Island, New Guinea and in the Admiralty Islands.

* * *

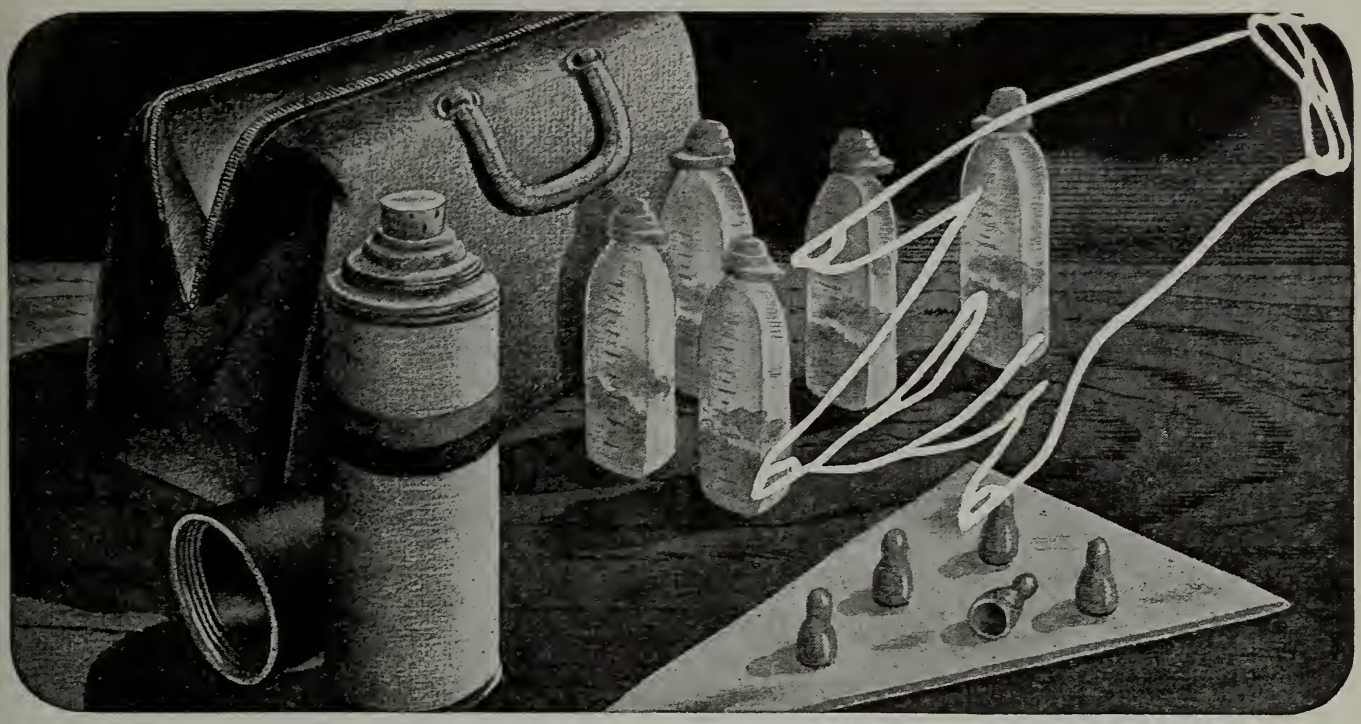
Major Edward B. Castle, Cleveland, who was chief of the general surgical section at the Station Hospital, Camp Chaffee, Ark., has been transferred to a similar post at the Crile General Hospital, Cleveland.

* * *

Lt. Comdr. Mendel Zeligs, Cincinnati, is on duty at an air station "on a beautiful and very comfortable Pacific Island", along with two other Ohioans, Lt. Comdr. Emidio Gaspari, Toledo, and Lt. Harry D. Morris, Cleveland. Dr. Zelings sent *The Journal* the following interesting description of a leper settlement which he visited:

"Leprosy is an ancient disease, described in the Bible, which we have all heard about but few have seen, so while stationed in this area I was glad of the opportunity to visit the Leper Settlement and Hospital in Kalaupapa, Molokai. This settlement was established about 1865, by the Kingdom of Hawaii, when a law was passed segregating all lepers. It was here that Father Damien spent his life and has a memorial established in his honor.

"The settlement is under the jurisdiction of the Board of Hospitals and Settlements of the



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Territory of Hawaii, and no one can visit it without a special pass from its superintendent. It is situated at one end of the island, completely isolated by the sea in front, and a cliff behind, which rises perpendicularly nearly 2000 feet, traversed only by a winding path around it to the plateau above. The scenery is superb, and the climate ideal.

"The lepers are given houses, and a monthly allowance for living expenses. Formerly they were permitted to bring their husband or wife and children. Now this is forbidden. There are four large houses, where children, and those who do not care to live alone, are taken care of. The people are encouraged to lead as normal lives as possible. They buy their own supplies in the village store, do their housekeeping, take care of their gardens and lawns, go to the movies, in fact they can do anything but leave the settlement. There are three churches here, Catholic, Protestant and Mormon.

"The Settlement is under the medical supervision of Dr. Norman R. Sloan, to whom I am indebted for his generous hospitality and for most of the information given here. He is a man of great charm, a former Lutheran medical missionary, who has treated leprosy in Liberia and the West Indies. His wife, a trained nurse and expert in public health, takes part in the nursing care at the hospital. Dr. Sloan is ably assisted by Dr. Edward S. Fish, who spent more than 30 years in China as a medical missionary.

"The hospital has about 50 beds, and is usually filled. Here are the most serious cases, the others come for treatment whenever they desire. It is quite modern, has good X-ray, operating room, laboratory and pharmacy. The nursing is done by Catholic Sisters, who have devoted their lives to this task.

"We saw every type of leprosy, from the mild modular, which gives a leonine expression to the face, to the crippling type, with complete blindness, loss of fingers and toes, and breathing through a tracheotomy tube. It was interesting to me that about one of every six lepers here eventually has to have a tracheotomy.

"A positive diagnosis is made only by finding the lepra (Hansen) bacillus in nasal smears of scrappings from ulcers. The patient may be released on parole if there is no clinical evidence of activity and six consecutive smears taken at two-week intervals are negative. The lepra bacillus is easily found in active lesions, is acid fast, and closely resembles the tuberculosis bacillus, from which it is distinguished by the fact that it can not be grown on artificial media or in the lower animals. The patients here have ranged in age from five years to 91 years. Males outnumber females three to two. The incubation period as far as can be determined is three to ten years. The most common presenting symptoms in order of frequency have been: (1) macules, (2) nodules, (3) anesthesia of fingers or toes, (4) ulcers, (5) swelling of skin and (6) muscle weakness of eyelids, face, hands and feet. The most common X-ray findings are: (1) destructive lesions of joints, (2) thinning of shafts of long bones which eventually disappear, and (3) charcot joint. Bone lesions are limited to hands and wrists, feet and ankles.

"Compulsory segregation has been effective in Hawaii. The number of active lepers has been reduced from 1175 in 1890 to 390 at present, despite a large increase in the population of the Islands."

A number of Ohio physicians have been in the thick of it on the Normandy Beachhead, according to news dispatches from that front. Among those mentioned have been: Capt. Robert M. DeWitt, Akron, reported to have been wounded by shrapnel while on duty with a medical attachment of the 29th Division; Major Wm. R. Althoff, Dayton, executive officer of medical batallion with the Ninth Division; Capt. T. B. Shipley, Canton, with a clearing station; Capt. Walter A. Reiling, Dayton, surgeon of an operating team on an LST boat evacuating casualties; Capt. Gordon T. Wagner, Cleveland, on detached service with a naval unit, and Lieut. (j.g) Dale L. Groom, Cleveland.

* * *

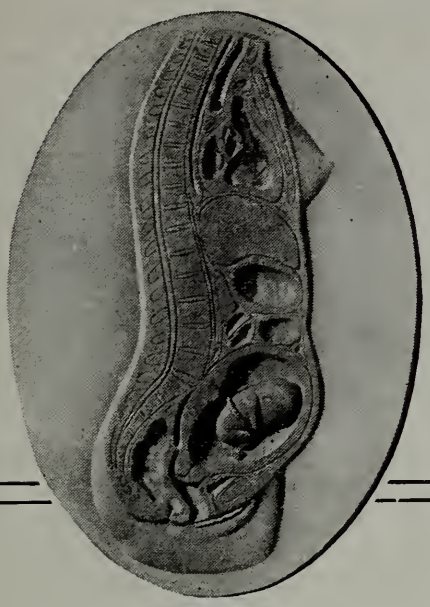
Lt. Comdr. T. E. Newell, Dayton, was home recently on a 15-day leave after almost two years in the South Pacific with the First Marine Division.

* * *

More changes of station within the United States: Capt. Edgar H. White, Cincinnati, Nichols Gen. Hosp., Louisville, Ky.; Lt. Col. George P. Tyler, Jr., Ripley, Veterans' Administration Facility, Pittsburgh, Pa.; Lt. James M. Shaffer, Dayton, Station Hosp., Camp Stewart, Ga.; Lt. M. D. Shilling, Ashland, Hollywood, Calif.; Major M. M. Miller, Steubenville, 516th Medical Clearing Co., Camp Rucker, Ala.; Capt Bernard Malasky, Cleveland, FRTU, FAAF, Squad "O", Florence, S. C.; Dr. Andrew A. Miglets, P.A.S., U.S.P.H.S., Youngstown, U. S. Marine Hosp., Seattle, Wash.; Lt. Col. Johnson McGuire, Cincinnati, Fifth Service Command, Ft. Hayes, Columbus; Lt. Harold C. Klein, Cleveland, Station Hosp., Spence Field, Moultrie, Ga.; Lt. Kendall Kennedy, Delaware, MDRP. Ft. Dix, N. J.; Lt. Duane Love, Sandusky, Hot Springs, Ark.; Lt. Col. H. J. John, Cleveland, Veterans' Facility, Bay Pines, Fla.; Capt. Franklin R. Geiger, Cincinnati, Nichols General Hosp., Louisville, Ky.; Capt Frank J. Fisher, Cleveland, Station Hosp., AAF 10, Camp Springs, Washington, D. C.; Capt. C. H. Bernard, Cleveland, 99th Evacuation Hosp., Camp Cooke, Calif.

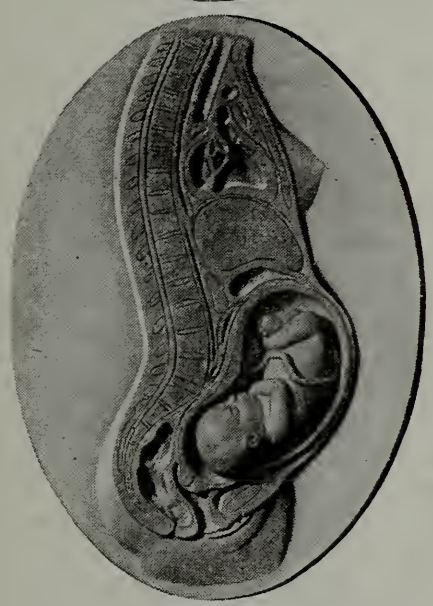
* * *

Service in both the Army and Navy during World War II is the unique record of Lieut. (j. g.) Robert M. Inglis, Columbus, who recently reported for duty with the Navy at San Francisco. Dr. Inglis was previously a 1st Lieut. in the Medical Corps of the Army, having been discharged because of physical disability in June, 1942.



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10 Lunar Months—Overdistension of recti and diastasis are obvious. Fetus and placenta fully developed. Head engaging (L.O.P.). Marked visceral displacement (upward and lateral). Marked lumbar lordosis "pride of pregnancy." Relaxation of pelvic joints.



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The Physician's Bookshelf

The 1943 Yearbook of Dermatology and Syphiology. Edited by Marion B. Sulzberger, M.D., and Rudolf L. Bear, M.D., ($3.00, *The Yearbook Publishers, Inc., Chicago)* appears for the twelfth consecutive time—better than ever. Most physicians, who have any interest in skin diseases, look forward with keen anticipation to the special article with which the editors have always begun this critical review of dermatologic progress. This time it is a guide to skin tests and other immunologic procedures. All those physicians who attempt to indict a particular chemical as the cause of industrial dermatoses will find indispensable the long list of concentrations and vehicles to be used in patch testing. This will afford such position great protection by indicating the proper strength.

Medical Care of the Discharged Hospital Patient, by Jensen Frode, M.D., H. G. Weiskotten, M.D., and Margaret A. Thomas, M.A., ($1.00, *The Commonwealth Fund, New York)* is the story of a successful experiment. Syracuse University College of Medicine, after a preliminary survey had revealed that 90 per cent of the cost of service of the general medical wards of the University Hospital was for chronic illness. Only one-third of these patients were receiving satisfactory medical supervision after discharge. The plan which was devised to correct this situation and to produce the necessary supervision of the patients in their homes resulted in saving the hospital three times the cost of the experiment. What is more important it released sufficient hospital facilities to permit the acceptance of several hundred additional patients. Still more important, of course, is the fact that these patients got better care. Here is a challenge of all concerned with community health.

Medical Clinics on Bone Diseases, A Text and an Atlas, by I. M. Snapper, M.D. ($10.75. *Inter-Science Publishers, New York)* presents 225 pages of text into which are bound 30 full-page plates in the form of actual photographs. This book presents observations and X-ray pictures which are especially helpful in the elucidation of certain special problems. The subjects are discussed by the former professor of medicine in Peiping Medical College and are intended for the student of constitutional disease and not particularly the surgeon. The book therefore has a much wider appeal.

Strophanthin. Clinical and Experimental Experiences of the Past Twenty-Five Years, by Bruno Kish, M.D., ($4.00, *Brooklyn Medical Press, New York City)* presents the work and opinions of the former professor of the faculty of the University of Cologne. This is a very stimulating and important summary of this too little understood drug.

Anatomy and Physiology Laboratory Manual, by Catherine Parker Anthony, B.A., R.N., ($2.00, *C. V. Mosby, St. Louis)* is a practical little manual designed by one of the instructors at Western Reserve University to demonstrate the most important facts and principles in this field.

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The Riddle of Cancer, by Charles Oberling, M. D., and translated by William H. Woglom, M.D., ($3.00, *Yale University Press)* presents a popular discussion for medical students and physicians who would like to learn about the trends in tumor research. He writes with authority and produces a very interesting set of lectures. His discussion of the relation of viruses to the causes of cancer is most stimulating especially in view of the recent work on nutrition and its relation to bodily resistance against viruses. The book is much more than this, however, and reviews the whole field of experimental cancer.

Allergy in Practice, by Samuel L. Feinberg, M. D., ($8.00, *Yearbook Publishers, Chicago, Ill.*) Recent years have seen a great many books written on the subject of allergy. Many of these have been intended for laymen and some for the profession. More recently, these have tended toward the two extremes—the simple outline of the subject and the large encyclopedic tomes.



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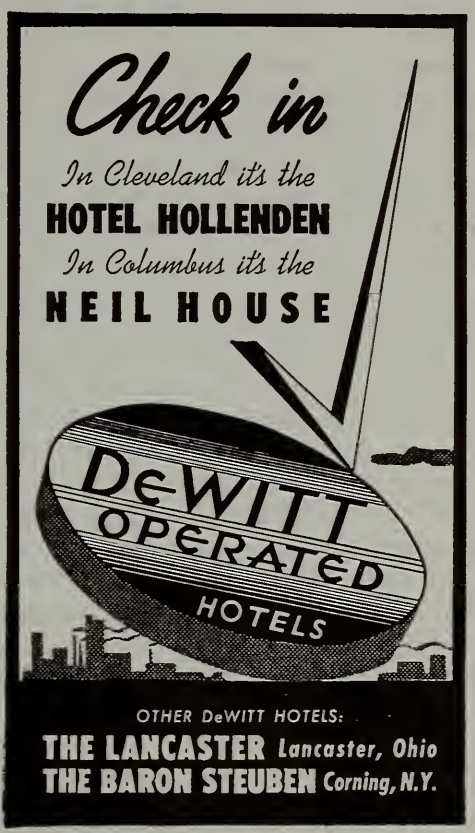
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There has, consequently, been a place for the volume which would give to the doctor a practical exposition of the subject detailed enough to be useful.

Now comes Samuel L. Feinberg, M.D., of Northwestern University who has done excellently in writing exactly this kind of book. He has written it from the viewpoint of allergy. One chapter in the book is devoted to pollens and it has been written by the author's friend, Oren C. Durham of the Abbott Laboratories. Following this 90-page chapter is the author's own on "Allergy to Fungi". This is one of the best accounts of this subject that we have seen. It presents all of the author's work and places great emphasis upon the practical. For example: six clinical symptoms that point to mold allergy at the patient's first visit before any study has been made; six respiratory and five other types of fungus sensitivity; working classification of fungi; clinical evaluation of the 18 principal allergenic fungi; three ways to study antigenic relationships; methods and results of mold surveys; cutaneous, mucous membrane, and passive-transfer tests; treatment.

Treatment of all allergic manifestations is well outlined. Feinberg has presented a critical review of the present status of almost every well-known measure with its indications. For specific therapy there are complete details with schedules, initial and maximal concentration of extracts, etc. While hay fever is treated in a comprehensive manner, an unusual proportion of the book is devoted to other allergies.

Typographically the book is arranged to make it easy to get a quick preliminary survey of any particular subject and to do a more critical study later. This makes the book equally valuable upon the desk of the general man and the specialist.

Proceedings of the 36th and 37th Annual Meeting of the Association of Life Insurance Presidents, 1942 and 1943, (Published by above Association, 165 Broadway, New York 6, N. Y.) presents an excellent series of addresses under the general title "Looking Forward With Life Insurance". This series of addresses is most interesting reading as this is the oldest form of American cooperation for security.

Gastro-Enterology, Volume II, by Henry L. Bockus, M.D., *(W. B. Saunders Co., Philadelphia)* treats of the small and large intestine and the peritoneum. It contains the high standards set by the first volume. Many of the author's distinguished colleagues at the University of Pennsylvania have contributed important chapters to this encyclopedic volume.

Synopsis of Tropical Medicine, by Sir Philip Manson-Bahr, M. D., ($2.50, *Williams & Wilkins Co., Baltimore)* is a typical little British manual presenting the subject in condensed form. It makes a suitable guide not only for military officers but for those of us who are apt to meet many of these diseases with the return of the soldiers to civil life.

The Art and Science of Nutrition, by Estelle E. Hawley, Ph.D., and Grace Carden, B.S., ($3.75, *C. V. Mosby Co., St. Louis),* Second Edition, is a textbook on the theory and application of nutrition from the University of Rochester School of Medicine and Dentistry. It presents 111 excellent illustrations and 11 beautiful color plates. It now brings us the newer knowledge of vitamins, dietary standards, and additional adjustments to diseases.

The Management of Neuro-Syphillis by Bernhard Dattner, M. D., with the help of Evan W. Thomas M. D., and Gertrude Wexler, M. D., *($5.50, Grune and Stratton, New York City)* presents the author's combined New York and Vienna experiences in a monograph to succeed the one formerly written in 1933. This is not, however, a revision of that German work, but an entirely new product, which as Joseph Earle Moore says in its forword is "an entirely new product which combines Old and New World experience".

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AMERICAN MEDICAL ASSOCIATION

Employed Physicians Now Subject To Employment Stabilization Plans

Physicians, dentists, veterinarians, nurses and sanitary engineers who are practicing their professions as employees and not as self-employed are now subject to employment stabilization plans of the War Manpower Commission. Also, the hiring of workers in the above professions is subject to applicable employment stabilization plans.

The following directive covering this matter was issued by Mr. L. E. Keenan, state director, War Manpower Commission:

"Effective at once, the hiring of workers in the above professions will be subject to applicable employment stabilization plans under the following conditions:

"Self-employed

"A large proportion of the persons in these professions are self-employed. Such persons who desire to change their status to that of a hired employee are not subject to employment stabilization procedures unless they are subject to controlled referral under the applicable stabilization program.

"Employed workers

"1. Less essential activities—Persons in these professions who are employed in other than essential or locally-needed activities are not subject to provisions of the employment stabilization program unless they are to be hired for work in a locally controlled occupation or are members of a group which is subject to controlled referral.

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"2. Essential or locally-needed activities—Persons in these professions who are employed in essential or locally-needed activities are subject to the provisions of the employment stabilization program applicable to other workers in such activities. The determination of eligibility for a Statement of Availability or referral is to be made by the United States Employment Service in the same manner as for other workers.

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"If the applicable employment stabilization plan requires that workers may be hired only upon referral by the USES, it shall be interpreted to include workers in these professions. All transactions involving the referral of workers in these professions must be reported by the USES field office, prior to referral, to the State Manpower Director for clearance with the Procurement and Assignment Service. This action is required to insure that the worker is referred to a job which will make the most effective contribution to the war effort. Cases reported to this office should be accompanied with a copy of the WMC-V-101, Application for Statement of Availability.

"Appeals

"Appeals of employers or workers covered by this instruction shall be made in conformity with Regulation No. 5 and the applicable procedures and instructions governing appeals. In preparing cases appealed from the decision of the USES, the WMC Area Director will report all facts to the State Manpower Director for consultation with the State Chairman of the Procurement and Assignment Service, whose recommendations will be transmitted to the Area Management-Labor Committee as part of the appeal hearing."

The Chicago Department of Health adopted a resolution recently requiring the coloring of boric acid in maternity wards as a precautionary measure to prevent the possible poisoning of babies. Similar action was taken recently by the New York City Health Department.

* * *

At the recent meeting of the House of Delegates of the Minnesota State Medical Association a resolution was adopted authorizing the Association to sponsor an enabling act for prepaid medical care plans, either on a state-wide or county basis, at the next session of the state legislature.

* * *

Dr. Charles A. Doan, professor and chairman, Department of Medicine, Ohio State University College of Medicine, Columbus, spoke on "The Differential Diagnosis and Treatment of Diseases Involving the Spleen", at the 77th Annual Meeting of the West Virginia State Medical Association, May 15-16, at Wheeling.

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JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.* GEORGE H. SAVILLE, *News Editor*

The Treatment of Dysmenorrhea: Practical Considerations*

MARION DOUGLASS, M.D.

THE handling of the problem of dysmenorrhea, which represents in effect an exacerbation of a normally uncomfortable process, requires for that reason especially careful evaluation. The variation in anatomical constitution, nervous tension of the individual, the threshold to pain and endocrine balance, are recognizable variables which must be weighed in any important consideration of the process.

Our recognition of the complexity of the relationship of menstruation to ordinary bodily function and its abnormalities as a whole and the increase in our knowledge of the delicate interlocking endocrine relationships has led to a needless and impractical elaboration of the therapy of dysmenorrhea. There has been too great a tendency to pour, per oram or through a needle, various commercial endocrine products into the sufferer from dysmenorrhea before the possible practical effect of such therapy has passed the most highly theoretical stage.

It is the purpose of this discussion to cull the practical points and methods of attack which are most worthy of attention through being productive of some demonstrable definite benefits and which should be done first in the treatment of dysmenorrhea.

DEFINITION OF TYPES

Essential dsymenorrhea is a disturbance which is characterized at the time of menstruation by severe cramp-like pains in the lower abdomen, from which the patient is entirely free during the inter-menstrual period. This form of dysmenorrhea is distinctive and must not be confused with the kind of menstrual pain which represents an aggravation during the menstrual congestion of the more or less continued discomfort from various pelvic disorders such as salpingitis, pelvic inflammation with misplacement, appendicitis, chocolate cysts, dragging ovaries, etc. This latter form of dysmenorrhea is more exactly termed "**secondary**" or "**acquired dysmenorrhea**".

Dysmenorrhea has been classified in the past as obstructive, congestive and neuralgic in origin. An obstructive dysmenorrhea seems at first, viewed from a mechanical standpoint, to be the simplest and easiest to understand. However, it must be remembered that in the majority of cases of so-called primary dysmenorrhea, certain anatomical variations or insufficiencies are almost inevitably present.

Dysmenorrhea of the obstructive type may be produced rarely by an actual kink at the level of the internal os. Various misplacements may certainly be responsible for certain cases. There is a distinctive type of woman in whom a large congested retrodisplaced uterus and edematous tender, and boggy ovaries are undoubtedly im-

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The Author

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portant inciting factors in producing the symptoms. Ovarian neuralgia with polycystic ovaries and thickened ovarian capsules is definitely associated with recognition of menstrual discomfort.

The greatest judgment must be exercised in advocating operative intervention upon these patients. Adenomyosis is an important factor in the production of dysmenorrhea (Graves).

Hypersensitivity to painful stimuli must seem inevitably to be associated with dysmenorrhea of any severe grade. The disease often seems to be one of deficiency: deficient flow, deficient size of organs, deficient muscular tone, inadequate endocrine and nervous balance and deficient resistance to unpleasant stimuli.

It might almost be said that there is a **dysmenorrhea type** which presents one or a number of the following characteristics: (1) Some degree of malposition of the uterus is usually present, very often a retrocession. (2) Moderate hypoplasia chiefly apparent in the form of an insufficiently developed cervix is frequently present. (3) Cicatrix-like stenosis at the internal os is occasionally seen. (4) Hyperplasia of the endometrium is often present but is not an invariable concomitant.

PSYCHIC BACKGROUND

Any consideration of dysmenorrhea without scrutiny of the psychic background of the patient is necessarily incomplete. The patient usually shows a psychoneurotic trend. She is apt to be of the nervous type, irritable, often introspective. Easy fatigability all too frequently characterizes the dysmenorrhea patient. Far from diverting our attention from disease of the pelvic anatomy, the presence of this psychic background merely emphasizes the importance of instituting well-chosen surgical or mechanical ameliorative measures. In other words, almost negligible anatomical defects can produce severe symptoms in women of this type of nervous and mental asthenia.

ENDOCRINE FACTORS

Endocrine factors are frequent. Disturbance of menstrual flow, scanty periods, slowness in getting a full flow started, particularly in the first day, and a period usually of short duration is the rule. Dysmenorrhea is rather rare in women with profuse periods of normal length. This suggests ovarian deficiency or dysfunction or disturbance of the interlocking mechanism of the hypophysis and ovary.

We have then, the dysmenorrhea type. The individual is of variable physique, but usually of all-round bodily vigor below the normal and with a somewhat hypoplastic anteflexed, or possibly retroflexed uterus, the cervix pointing down the vaginal canal with a small external os and a sharp kink in the cervico-uterine junction. The uterus may be (1) short and squatty of the so-called dwarf type or (2) elongated and slender in lateral measurement, i.e., the typical infantile or hypoplastic uterus.

SYMPTOMS

The patient with essential dysmenorrhea usually feels perfectly well between her periods as far as any local condition is concerned. At the menstrual period however, either just before or at the time of the appearance of blood, the patient is seized with severe, often agonizing cramp-like pains in the lower abdomen, which extend into the back or down the legs, lasting with a few intermissions from a few hours to one or two days. During this time the patient is more or less incapacitated from normal activities and is often confined to bed. Severe headaches and general malaise are often present; nausea and vomiting are not uncommon. It is frequently relieved by married life, but it is sometimes aggravated by it. Patients with essential dysmenorrhea are very apt to be sterile and it must be remembered that childbirth has cured more cases of dysmenorrhea than all other forms of therapy.

TREATMENT

The important thing to consider in this disease is, of course, the treatment. The patient's confidence is needed in the treatment of dysmenorrhea. The dysmenorrhea patient, usually of the psychneurotic type, with the self-centered outlook, and with exaggerated evaluation of her internal sensations, is on a par with a person who is conscious of his heartbeat; a person who stands in need of a tactful but vigorous debunking of the excruciating character of her symptoms.

One must cultivate the patient's confidence and have an ideal and sympathetic relationship between the doctor and the patient. This is essential. She must believe that you can do something for her because the slight but definite neurotic mental habitus present almost invariably makes a factor of psychotherapy implicit in any form of treatment which is instituted. Additionally, because such a patient having a definitely lowered threshold to pain, may have some subjective pain with a perfectly normal anatomical set-up, and hence is apt to have very serious trouble if she possesses a very slight amount of pathologic anatomy. Not that serious or radical surgery is to be recommended in spite of the fact that Graves recommended suspension in stubborn cases of dsymenorrhea and reports 75 per cent of cures. We have been unable to see that this is necessary. It is however, our experience that properly chosen operative procedure is successful in about 60 per cent of cases, definitely more than one-half. This coincides definitely with Graves' large series of cases at Harvard.

(Weir, Miller, Graves). In the use of the inlying uterine pessary, the important things to be considered are these: Careful pelvic examination. If the patient has a misplaced stenotic cervix, (anteflexion with retrocession, sharp kinking of the cervix of the uterus, retroversion or lateral flexion) this should be corrected. This properly can be done by means of a thorough dilatation up to 30 to 35 French or with the insertion of a stem pessary, the silver Carstens type being preferred to be left in for two or three periods.

Such a uterus dilated and curretted and fitted with the pessary will tolerate the pessary very well in almost all cases and the danger of a resulting pelvic infection is almost nil. Our favorable experience, over a period of 25 years with the intra-uterine stem pessary of the Carstens type in a series of several thousand cases, (Weir, et al) makes it difficult to understand the almost universal opprobrium with which this instrument, so harmless and effective in properly selected cases, is regarded.

The patient must however, be free from inflammatory disease of the tubes or marked cervical infection. The cervix-uteri dilated and then straightened in the axis of normal anatomy is a sine qua non in therapy. In other words, the creation of the average normal mechanical arrangement in the pelvis in 19 out of 20 uncomplicated cases can be attained without abdominal surgery.

The use of the stem pessary and the trauma of currettage often seem better to stimulate the uterus to a more profuse and hence more normal flow than other surgical procedures. Suspension, trachelorrhapy, hysterectomy are all usually ill-advised and are only applicable if at all, for the very exceptional case. Repeated mechanical dilatation is sometimes necessary (Jeff Miller) and will greatly relieve but sometimes it is necessary to repeat it as often as once a year.

However, the minor operative procedure is undoubtedly a factor of psychotherapy in these cases. Sympathectomy is a radical procedure for such a relatively minor complaint. Curtis states that thorough presacral nerve resection relieves nearly all cases of primary dysmenorrhea. He recommends it to be reserved for intractable cases only, however, for it is an important undertaking to be resorted to only after other measures have proved futile.

Replacement of the uterus in normal position and dilatation of the cervix, attempting to develop the uterine musculature produced by dilatation and curettage and especially the wearing of a stem pessary for a short period is our most effective weapon from the surgical standpoint.

I say this designedly in the face of dicta almost universally condemnatory of the method, largely because in incapable hands, complications have followed the insertion of the pessary in obviously infected areas. Permanent good drainage likely to be obtained by the method as well as development of the musculature of the uterus, is probably due to the presence of the foreign body and the trauma of the dilatation and curettage. An occasional case will not tolerate the inlying pessary due to excessive bleeding or cramps but these are rare. The pessary may be removed and a favorable result will usually be obtained. Further the fact that pregnancy follows so frequently the removal of a stem pessary in the habitually sterile woman (the first period is fairly frequently missed) would seem to dispose of the argument that the instrument is dangerous per se or "unsurgical".

DRUG THERAPY

Drug therapy as a whole is unsatisfactory. Remedies in common use may be classed as the analgesics and antispasmodics. The most effective drug has been codein in the very serious cases. Fairly large doses of aspirin and simple bromides seem to be definitely of value. Atropin is probably the one of most importance. It is best used in an average dose of 1/150 gr. three times daily combined with aspirin. This about covers our effective drug therapy. Atropin should be started about two days before the period is expected and is often highly effective. The simple barbiturates are about as effective as any other drug therapy.

GLANDULAR THERAPY

In view of the work of Novak, Reynolds, and others, daily injections of the anterior pituitary-like hormone, theoretically at least, inhibit uterine contractions. Injections of Antuitrin S or others of the commercial preparations on the first day or two, or just preceding menstruation, one to two cc. may be sufficient. In summary, our effective therapy is limited to the following weapons in the arsenal, any one or all of which may be employed:

1. Psychotherapy, principally consisting of getting the confidence of the patient.
2. Proper sedation-analgesia during the time of her periods, codein, atropin, benzylbenzoate, etc., we have found effective.
3. Antuitrin S. or other hormone therapy with progesterone effect.
4. Dilatation and curettage if necessary, easy under evipol with insertion of an intra-uterine stem pessary (of the Carstens type preferably) combined with a Smith-Hodge pessary in retroflexion-retroversion.
5. Sympathectomy.

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Wartime Food Problems

MARTHA KOEHNE, B.A., M.A., Ph.D.

THIS country has the reputation of being the best-fed nation in the world both before the present war started and now, after a year or more of food rationing. One needs only read comments of our repatriated citizens who have come back to this country recently from Europe and the Orient to believe this statement. Yet there is so much misunderstanding about our food problems that it seemed wise to present, to those who are working so hard to keep the public informed in the field of food and nutrition, a carefully planned statement of both our food problems and those of the world. During years of total global war the food and nutrition problems of any one nation are bound to be affected by those of all the nations of the world. The review will close with a discussion of how this country can best make its contribution to the solution not only of its food problems but also of the food problems of those nations that have experienced the horrors of active warfare and of years of occupation by a ruthless enemy.

The Author

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FOOD SITUATION IN UNITED STATES TODAY

First, what is the nutritional status of our population?

The Food and Nutrition Board of the National Research Council has recently published an excellent review of this subject.[1] Authors of this bulletin recognize that severe, acute cases of dietary deficiency disease are relatively few in number, compared with the milder, chronic, subacute types that require new and specialized skills to detect. Some of the present confusion as to the prevalence of malnutrition comes from the failure to recognize that not mere absence of disease but optimum nutritional status should be looked for, with its positive characteristics of buoyant good health and body efficiency, as well as attainment of the maximum of physical, mental and emotional health that one's inheritance permits.

Sherman and colleagues[2,3] showed increased growth and efficiency, decreased death rate and increased vitality at all ages in rats by improvement in a diet **heretofore regarded as adequate** because it permitted the rearing of 50 generations of animals that, by earlier standards, were **apparently** normal. Farmers have long appreciated the economic advantages of properly feeding their livestock.

Orr and Gilks[4] several years ago reported observations on the health of two African tribes that lived close to one another but had quite different food habits. The first tribe consumed quantities of milk and meat, while the second one lived chiefly on cereals, tubers and legumes. The second tribe was markedly inferior to the first in physical development, both the men and women being on the average three inches shorter and 23 to 27 pounds lighter in weight than were the men and women of the first tribe. They were also much more susceptible to chronic respiratory disease and parasitic infections, and were generally inferior in health characteristics. That these differences were directly related to food habits was confirmed by improvements that resulted in the second tribe after changes in food habits were instituted.

EFFECT ON HEALTH

There are many reports in the literature of this country and other nations on improvements in growth and well-being resulting from improvements in the food eaten by groups of children. These changes were associated with better scholastic and attendance records. Ebbs and colleagues in Toronto and Burke and associates in Boston have recently demonstrated the striking influence of good nutrition vs. poor nutrition on the successful progress of pregnancy and of childbirth and on the health of infants at birth and for six months following birth. These workers were able to greatly reduce the incidence of stillbirths and premature births, as well as many serious complications of pregnancy merely by provision of a satisfactory diet during pregnancy.

There are many reports in the literature, of which references 5 through 10 are representative, indicating that the health and normal functioning of various body tissues and general human efficiency are affected by the nutritional completeness or inadequacy of the diet. Recent studies by Cannon in Chicago indicate the relation between low protein intake and resistance to infection, which may help to explain the greater prevalence of infectious diseases among poorly-nourished

Presented at Refresher Program for Volunteer Nutrition Teachers of Franklin County, May 4, 1944.

populations. Evidence is accumulating of a close relationship between chronic absenteeism among industrial workers and poor nutrition.

DIETS DEFICIENT

Many dietary studies have been conducted during the past 10 or 12 years, covering thousands of people of all ages and occupations in various sections of the United States and at different seasons of the year. All of these reports agree that comparatively few people are eating types of diets that could be called optimal nutritionally. A much larger proportion of our population consumed food that failed to meet the standards of the new yardstick of good nutrition by more than 50 per cent. The largest proportion of diets, however, were deficient by less than 50 per cent of the newly established standards. Most of these studies were conducted in pre-rationing days when choice of food was limited only by the appetite and pocketbook, for we had no apparent food shortage previous to 1942. However, few of our people understand that this country has never produced enough food so that every citizen could have his full quota of valuable protective foods such as milk, meat, fruits and vegetables.

SIGNIFICANCE OF FOOD SHORTAGE

Next we shall consider the significance of present food shortages.

Data presented in this section are taken mainly from three sources.[11,12,13] Food production fell to very low levels from 1932 to 1935 due to severe droughts and to federal crop restriction policies and did not become apparently normal until 1939. For purposes of comparison, food production each year since 1939 is frequently expressed as percentage increase over the average for the period from 1935 to 1939.

In 1940 food production was 10 per cent higher and in 1941 was 13 per cent higher than this average. In 1942 production jumped to 26 per cent above the 1935-1939 levels, and was six per cent higher than the goal set. In 1943 total production was four to five per cent over 1942 but increases were spotty, being especially notable in soybeans, peanuts, pork, poultry and eggs. We do not know what the picture for 1944 will be.

It is interesting that shortages of food began to show up at the close of 1942, the record-breaking food production year. Why? Shortage of some foods was due to the submarine menace which restricted imports of coffee, sugar and oils and which lessened the activities of fishermen along our seaboard. This could not explain all the shortages, however.

In 1942 our armed forces required 7.5 per cent of our food supply, while lend-lease shipments took another 6 per cent and about 2 per cent was shipped out through regular channels of foreign trade. This totalled 15.5 per cent, leaving 84.5 per cent for civilian use. Inasmuch as 26 per cent more food was produced this year than was the average for 1935-1939 during which time no shortages developed, this means that civilians got about 10 per cent more food than during these earlier years and still this was not enough. The explanation lies in the fact that the phenomenal growth of our war industries with associated decrease in unemployment and increase in wage rates greatly improved the average income level of our population. Because of removal of many common avenues for spending money, due to war priorities on raw materials for their production, civilians had fewer ways to spend their increased earnings. However, they could and did buy more nearly the amounts of milk, meat, butter, friuts and vegetables that they should have in comparison with what they had been able to buy in depression years. It was this unprecedented civilian demand that caused and is still causing shortages in some of our most valuable common foods.

In 1943 it is estimated that 10 per cent of the available food went to our Allies under lend-lease contract, while our armed forces required 12 to 14 per cent and we still had to ship about two per cent through regular foreign trade channels. This left only about 74 to 76 per cent of the 1943 crop for civilian use while civilian demands were even higher than in 1942.

In all probability an even smaller percentage of the 1944 crop will be available for civilian use due to larger proportions being needed for our armed forces and by our Allies and for use in foreign relief as countries are liberated from Nazi control. We must keep in mind that the percentages reserved for our armed forces and for overseas shipment will not represent uniform percentages from all food commodities.

Due to the necessity for economizing on shipping space and for giving consideration to the necessity for shipping only those foods to our Allies and for relief purposes that will supplement what they already have, some items of food will be in greater demand for such purposes than will others. For example cheese, dried eggs, dried milk, dried fruits and legumes, dried vegetables, etc, are sent overseas in greater proportion than are fresh or canned fruits and vegetables, cereals, potatoes, etc. Civilians, for example, get less than half of the dried fruit supply.

MUST MAINTAIN RESERVE

Many civilians, too, do not realize that subsistence divisions for our armed forces are required to keep a three months' reserve supply of food for all forces in camps in this country and a nine months' reserve supply for all overseas forces, in order to be able to meet promptly all emergencies and sudden changes in war plans.

If we understand these huge problems our government is up against, we can more readily understand why spotty shortages sometimes develop, especially near ports of shipment. On the other hand, we will all recall reading occasionally that the army has released some of its reserve stocks of canned or other foods for civilian use.

Finally civilians must understand that lend-lease contracts entered into by this country provide us with much badly needed material in return, wherever possible, for what we send out. For example New Zealand and Australia are supplying most of the food for our soldiers located in that area. Great Britian has contributed a great deal in the way of transports, building camps, and supplying uniforms and weapons for soldiers located there and in the North African campaign.

The following table gives a more concrete idea of the proportions of some of the various types of food needed for our armed forces and shipped under lend-lease contracts in 1943, expressed as percentage of our 1943 food supply:

	Needed by armed forces 1943	Sent under lend-lease contracts 1943
Fresh and canned meats	17	12
Canned fruits and juices	40	less than 1
Citrus fruits, fresh and canned	15	5
Canned (and dried) vegetables	26	1
Butter	15	6
Other edible fats and oils	6	22
Cheese	11	19
Canned milk (and dried)	32	12
Canned fish	10	21
Eggs (fresh and dried)	10	14
Dry beans and peas	15	17

Our soldiers consume an average of 5¼ pounds of food per day compared with 4½ pounds needed by hard working adult civilians and 3¾ pounds eaten by the average civilian.

FOOD SITUATION IN WAR-TORN NATIONS

First, what do we know about the health and nutritional status of European nations?

Published reports [14,15,16,17,18,19] are cited in support of comments made on this subject. Hitler has used food as a double-edged sword. He has systematically robbed conquered nations of their valuable protective foods, sending these foods to Germany to improve the nutritional condition of especially favored groups of Aryan Germans, such as soldiers, hard working civilians, young children and pregnant women. He has purposely deprived people in conquered nations of essential foods in order to reduce birth rates, to make it increasingly difficult to raise children, and to weaken their power of resistance to Nazi control.

In Germany and in her conquered nations, all foods are rationed, including food eaten in restaurants. Ration allotments are made on the basis of age and occupation. Often in occupied countries, however, some of the items in the meager food allotments are unobtainable, especially as regards fats, meat, sugar, and milk.

Greeks, Jews everywhere, and Poles have fared worst of all, but since August, 1942, Germany has permitted allied nations to send 15,000 tons of food to Greece each month. Ration allotments to people in conquered nations usually vary from 1,400 to 1,600 calories per day, a maximum seldom obtainable, however, because of frequent shortages in allotment foods. Polish Jews get about half as much and their choice is limited to what the Germans in charge choose to send in to their Ghettos. Everywhere the all-powerful Germans and their families have first choice of foods in the public markets and can usually buy foods not permitted to the native inhabitants except through black markets.

GERMANY'S PROBLEM

Germany's food control program is steadily weakening due to a number of factors. 1. Heavy slaughter of livestock in the early days of the war when Germany thought the war would be over very soon. 2. Poor cooperation of farmers and peasants, who hoard their produce at every chance for their own use, to supply black markets and to help secretly needy friends and relatives in cities. 3. Reduced production levels due to manpower shortages and scarcity of fertilizer and machinery, as well as to the ravage of war in some localities. 4. Transportation difficulties which make it very hard to supply civilian markets with the food farmers are permitted to sell.

The satellite nations, Hungary, Bulgaria and Roumania have fared almost as well as Germany, at least until recently, averaging about 2,600 calories per day. Italians have had only about 1,800 calories daily. Portugal, Sweden and, until recently, Denmark have fared slightly better than Germany. In Spain the prevalence of abject poverty has increased malnutrition.

In Russia only the army is really well fed. Stalin, knowing the serious transportation problem, preferred that war weapons instead of food be sent to Russia by lend-lease contract. All foods, including those served in restaurants, are rationed. Even persons working in war industries are on very short rations. The re-taking of the fertile Ukrainian plains in time for spring planting will ease the food situation there considerably.

CONDITIONS IN ENGLAND

In England only about 50 per cent of the food is rationed, but luxury items are not available. School feeding programs require no ration points, and about twenty million three-course, 1,000 calorie meals, carefully planned and prepared under expert supervision, are eaten daily by the general public in special "British restaur-

ants" without ration points. England is producing about 50 per cent more of its own food than was done in pre-war days and gets considerable food from us under lend-lease arrangements, not only to help feed her armed forces but to help in the civilian feeding problem, too. Many of the British people are in better physical condition than in pre-war days and all are better off than are most Europeans. What evidence do we have as to the effects of food restriction on the health of other nations in Europe?

In Athens pre-war deaths from all causes averaged 40 per day, while in 1942 they averaged 500 with figures rising as high as 1,700 per day. In Warsaw there was no typhus fever in 1938, while in 1941 there were 17,800 cases, 88 per cent of these cases being Jews. Death rates in Warsaw were 11.4 per 1,000 in 1939 but 29.8 per 1,000 in 1941. Deaths from tuberculosis were 2,950 in 1938, 6,543 in 1941 and 8,840 in 1942. In Poland the birth rate dropped from 24.6 per 1,000 in 1939 to 9.84 in 1941, with one baby out of three dying before one year of age.

SUFFERING IN OCCUPIED EUROPE

Throughout occupied Europe housewives are probably suffering most. They stand in line for long hours each day for their families' food supply and starve themselves in order to give more to their children. Children in these areas show serious loss of weight instead of steady gain in weight. Adults, too, are losing weight alarmingly. Edema is spreading due largely to a too low protein intake. Swiss physicians report that diet deficiencies in France in calories, protein, minerals and vitamins are producing deficiency diseases, delaying growth, and greatly lowering resistance to acute and chronic infections in French children. Tuberculosis, rickets, scurvy and dermatitis are rapidly increasing and living conditions as well as hunger are having a serious effect on delinquency and on the mental and social attitudes of children. In some countries there are reports of alarming increases in vision and hearing defects. In all these countries hunger is combined with suffering from cold, due to lack of fuel for homes and to lack of clothing and shoes.

Certainly morale is being undermined. Morale has been defined in terms of maintenance of an unabated faith in ultimate triumph in spite of suffering and adversity. "A hollow stomach has a way of softening faith though the will to believe is strong". One marvels that the morale of Russians, Slovaks, Greeks, Serbs, Norwegians, Dutch, Belgian, French and the Chinese has held up as it has. Perhaps hatred has a way of counteracting the effects of hunger on morale.

What plans are the allied nations making to provide relief to these nations?

With conditions such as just described affecting so many millions, the United Nations Relief and Rahabilitation Administration, established Nov. 9, 1943, by 44 allied nations, including governments in exile of conquered nations, is working actively on plans to provide necessary relief as soon as sections are released from Nazi control. All intelligent persons can understand the absolute necessity for this if peace, not utter chaos, is our goal. Cordell Hull has said:[20] "With victory achieved, our first concern must be for those whose sufferings have been almost beyond human endurance. When the armies of our enemies are beaten the people of many countries will be starved and without means of procuring foods; homeless and without means of building shelter; their fields scorched, their cattle slaughtered; their tools gone; their factories and mines destroyed; their roads and transport wrecked. Unknown millions will be far from their homes—prisoners of war, inmates of concentration camps, forced laborers in alien lands, refugees from battle, from cruelty and from starvation. Disease and danger of disease will lurk everywhere. In some countries confusion and chaos will follow the cessation of hostilities. Victory must be followed by swift and effective action to meet these pressing human needs."

METHODS ADOPTED

According to Black[12] this relief will be: 1. Day by day food until some can be grown locally or secured through normal channels of trade. 2. Agricultural reconstruction, such as seeds, fertilizer and machinery, as soon as growing season starts and continued until pre-war production levels are restored. The army will be responsible for feeding civilians during military operations and for six months afterwards, then local civilians will take over. Forty-three allied nations will pool their resources. In making plans, nutritional needs, available food resources and food customs of each nation are being studied in order that the food provided to each nation will be familiar and usable and will not duplicate what they already have.

Black says that the easiest mistake would be to be too liberal with direct aid. He says we should give sparingly enough so that persons have to work hard to get more and that relief should be withdrawn a little faster than persons can replace it with their own efforts. Plans being made provide for food at a level of about 70 per cent of nutritional requirements except for the very young, pregnant or nursing mothers and those who are ill. According to Helen Mitchell,[21] former assistant to Governor Lehman, our chief representative in United Nations Relief and Rehabilitations Administration, grains will be the major item of food provided and oils and fats will be sent where most needed. Other foods will be legumes; fish—forms are now being canned that are unfamiliar to us but that have been tested and found

acceptable abroad—daily products for use only by special groups such as infants and young children and pregnant or nursing mothers; dehydrated soup powders, containing varying proportions of peas, soybeans, dry skim milk, special yeast, dehydrated vegetables, seasoning; dry mixes containing 10 to 15 per cent soybean flour, for local preparation of macaroni, spaghetti, noodles, etc.; porridge and cereal mixes containing different cereals for different nations, soybean grits and with or without dry skim milk. The use a given country will make of the food sent, according to their food customs, will determine the make-up of various dry mixes sent.

Some clothing and shoes will have to be sent as well as medicines. According to Lehman[20] the "amount we spend in helping them become self-supporting is trivial compared with the amount they will spend with us once they resume the creation of wealth and the purchase of the fruits of our industry". "We should not grumble when the war is over, because we must get along for a while on less meat and butter and eggs. We should thank God that we have enough money and goods so that we can share with the less fortunate, so that they can be strong physically and spiritually, to work with us to finish the job—to build the kind of world we so much desire". Black says the slogan **"Food to Win the War"** will gradually merge into **"Food for Relief"** and this, in turn, into **"Food to Make and Keep the Peace"**.

THIS NATION'S RESPONSIBILITIES

How can this country make its contribution to world food relief and still maintain good civilian nutrition?

A. Making Necessary Adjustments in Agricultural and Food Habits:

Detailed information on this subject will be found in references 12, 13, 21, 24, 25 and 26, from which the following brief summary was compiled. Careful studies have been conducted in this country and various parts of the world of yields of different kinds of food per acre and per man-day work, in terms of tonnage produced and of pounds of calories, proteins, vitamins and minerals. These studies reveal that any crop that can be used directly as human food, yields its maximum value when so eaten.

Only sparsely settled nations can devote much of their agriculture to production of livestock. In the thickly populated Orient grains are used almost exclusively as human food. The dairy cow, however, can eat food largely impossible for human beings to eat and can convert such food very efficiently into an excellent food for man. Per acre of feed and forage required and in terms of meat processed and ready for human consumption, wheat acreas give nine times as many calories as those devoted to raising pork, while per labor unit devoted to raising an acre of food, 55 times as many wheat calories are produced as pork calories, yet pork gives better results than other forms of meat. Labor-units produce 20 times as much wheat protein as of beef protein.

Acres devoted to the production of poultry and eggs or of milk yield three times as many calories as if devoted to pork production; per labor unit they produce 11 times as many calories as if devoted to pork production.

On both the acreage and labor unit basis, field crops as well as fruits and vegetables yield more vitamin units than do livestock products, but we must recognize that it is impossible for mankind to eat enough vegetables to get the vitamins needed from these sources. We need some of the more concentrated foodstuffs, too, for we get three-fourths of our calcium and much of our riboflavin from dairy products and over one-half our niacin and two-fifths of our thiamin from meat, poultry and fish.

In times of world-wide need for increased food production, animals that can grow and thrive on forage grasses found on ranges and on hilly and swampy grounds are more suitable livestock to raise than those that eat as much grain as do hogs. Among these animals, those that produce milk are to be preferred to those that yield only meat. England has for several years restricted livestock production largely to dairy cows and poultry. Poultry production is sound when there is considerable part-time and left-over labor available for their care. Grain needed by dairy cows and poultry to supplement their diet may add more to food production than if fed to hogs.

In the presence of greatly increased world needs for food, human calories should largely come from cereals, legumes, potatoes, sugar beets and vegetable oils. Proteins should come in greater proportions than is the custom of many in this country from cereals, legumes including soybeans, and dairy products. All available grass lands and forage should be used for dairy cows first, production of beef cattle and sheep being secondary. Milk should be used as whole milk preferably, with much smaller proportions used in making butter, cheese, and cream, because in making these products milk residues are so largely lost for human use. Land not needed for direct human food production should be used for production of food grains to be used first to supplement grass and forage for dairy cows and any left over to be used for feeding hogs and poultry. Orchards should be maintained at high production levels and large quantities should be produced of such vegetables as yield greatest units of vitamins and minerals per acreage and labor units,—carrots potatoes, tomatoes, kale, onions, beets and snap beans. Left-over labor may

be used for production of other vegetables and poultry, provided this fits into the foregoing program.

B. Food Production and Distribution Problems:

We should adopt a more intensive type of agriculture. We feed only 32 persons per 100 acres of crop land plus one-third of the 380 million acres of pasture land that is rotated for crops. Denmark, on the other hand, feeds 58, Sweden 69, France 80 and Great Britain 140 persons per 100 acres of crop land. This more efficient use of land is accomplished by better care of the soil through more intensive fertilization and cultivation, and by using the soil for the production of those foods that give greatest yields of food per acre and per unit of labor. Measures also must be taken to prevent soil erosion and to restore soil to denuded areas. If our farmers would cooperate 100 per cent in such a program and our people's food habits could be adjusted to a somewhat more restricted variety of foods available, we, too, could produce a great deal more food for our own use and to help feed the starving millions elsewhere.

More machinery and more efficient use and care of all available farm machinery would help alleviate the man-power shortage. Persons who have special skills in those types of farm work requiring such skills should be exempt from military service, leaving other tasks for the unskilled and inexperienced part-tme or full-time workers. Better distribution and management of farm placement offices are perhaps also needed to help in the present man-power shortage on farms.

A big transportation problem is solved by home production and food preservation programs for vegetables that are bulky and perishable and require such specialized transportation facilities. Victory gardens should therefore be emphasized even more this summer than last, with special emphasis on products easily raised such as tomatoes.[12,13]

The world needs twice as much food as is now produced.[27] If everyone all over the world were to have the kinds and amounts of food needed for good nutrition it would take 50 per cent more cereals, 90 per cent more meat, 125 per cent more milk and dairy products, 125 per cent more vegetables oils and 300 per cent more fruits and vegetables.

C. Thrift in the Use of Available Foods:

This country is notorious among nations for its waste of food as well as of soil and soil fertility. Careful estimates[11,28] show that we have annually wasted from 20 to 30 per cent of the food produced. Production is subject to many variables, some of which are beyond the power of man to control, but conservation of food is large controllable.

A recent article[28] tells the story of some of the efforts being made by our armed forces to lessen food waste.

Waste takes place in hotels, restaurants and public institutions due to over-stocking, poor storage facilities, preparing too much food, inexperienced help. Much plate waste could be avoided by better methods of food preparation, use of simpler menus, avoidance of serving to patrons courses they do not want, giving too large portions, etc.

Waste in wholesale houses and public markets results from poor storage facilities and poor methods of storage; leaving fruits and vegetables stand in the sun; removing husks and outer leaves from such foods as corn and cauliflower; bruising fruits and vegetables due to careless handling by customers and inexperienced help; failure to keep vegetables moist by spraying in warm weather, and other factors.

Home waste of food is chiefly in fruits and vegetables, next bakery products, with probably least waste of meat. Just one less slice of bread per family thrown into the garbage pail each week amounts to two million loaves per week! Imagine how far that would go in feeding Europe's starving millions! Herbert Hoover said in May, 1943: "World peace is a peace of bread. The first word in a war is spoken by the guns—but the last word has always been spoken by bread". The suggestion is frequently made that bakers make half-pound loaves for bachelor apartments and for families of one or two sedentary adults. Instead of that the size of the loaf has recently been increased. We lose 10 to 25 per cent of the potato in peeling it raw to say nothing of the greater loss of Vitamin C in subsequent cooking of the peeled raw potato.[30] Much of the nutritive value of fruits and vegetables and meats is lost through wrong methods of preparation and service. Many persons make a habit of not eating everything they take on their plate in the belief that it is poor table manners to clean their plates. We should shame them out of such foolish ideas in these days of acute food shortage. Do we raise lettuce parsley and watercress just to decorate a plate?

If we could get every person to do his utmost to eliminate food waste for which he is responsible, the results would be the same as if food production this year were increased as much as 10 per cent. This would be amply worth the effort.

D. Food Preservation:

To lessen the strain on our already over-taxed transportation facilities as well as to insure each family a supply of canned vegetables and fruits ration-free for next winter, housewives are

expected this year and next to can, dry, quick freeze or winter-store products of victory gardens and otherwise available fruits and vegetables. This year there will be general agreement among all professional advisors as to policies and practices for home food preservation. State and county nutrition and Victory Garden committees are forming joint food preservation committees to give all possible help to housewives in order to lessen food waste through accidents or spoilage and to increase the flavor and nutritive value of resultant products. In many communities Food Preservation Information Centers will be established for individual consultation and demonstrations will be conducted for groups on request.

E. Cooperation in the Food Rationing Program:

The general public must be taught that certain foods are rationed because they actually are scarce, not as a mere show of power by autocrats. The point system has been found to be the fairest and most flexible one yet devised for administering food rationing. When the supply of a given food is plentiful it has low ration point value or is ration-free; when the supply of other foods is low, point rationing permits their fair distribution to all alike, not to just the favored few with the most money and shopping time. Fluctuation in ration-point value permits quick adjustment of supply and demand, for few can buy freely of foods with high ration-point value.

People must be convinced that it is their patriotic duty to cooperate whole-heartedly in the rationing program and accept graciously reductions in certain favorite foods instead of trying to get, surreptiously through black markets, more than their fair share. There undoubtedly are just criticisms occasionally of the way the program is being administered, but the principle is sound and deserves our hearty cooperation. Those in charge now seem to be trying very hard to iron out injustices and unfair practices. Mistakes in judgment were bound to occur in establishing such a program among personal-liberty-loving citizens of the United States.

We can stretch our ration point allowances in two legitimate ways. First, by liberal use of foods with low ration point value or that are point-free. If these foods are familiar,—as are cereals,—we need to learn and to teach others varieties of ways in which they may be used, in combination with foods of high point value, such as meats, to stretch their flavor, or with fruits, vegetables, etc. We can learn much from our friends who have come to this country from foreign lands. Many of our immigrants are experts in the use of simple cereal foods making a wide variety of delicious foods from them. If other ration-free or low-point foods are unfamiliar to us for use in cookery,—such as peanuts and peanut butter, soybeans, soybean flour and grits,—we must learn some of the many ways to use them.[31,32]

The **second** way we can stretch our ration points is by restricted daily use of foods of high point value, much as we may enjoy eating them. Black markets are wholly **unpatriotic** and **undemocratic** and can be abolished when the public refuses to patronize them. High point-value foods we buy should be used to the maximum extent in stretching their flavor and nutritive value. Eggs and milk are point-free and a soft custard can be made from two egg yolks, ½ tsp, salt and one cup of milk. When this custard has cooled to lukewarm, it can be beaten into one-half pound of whipped butter, making one pound of delicious spread for half the ration point value of butter. Meat can be combined with vegetables and with cereal products. Meat bones can be used for making soup stock and meat fat can be used in place of other fats that have point value.

Miss Harris[35] said: "As civilians we can so choose that our everyday foods can be our weapon for helping win the war and the peace or by our own choice we can lengthen the war and endanger the peace, for it has also been aptly said that hunger can lose the war and wreck the peace". We must cooperate in the food rationing program and show in this way that we are willing to SHARE available foods.

POSTWAR PLANS IN FOOD, NUTRITION AND AGRICULTURE

Many foods new to most of our people are now being prepared for overseas shipment. These will be available to us as soon as the present emergency is over. They will have been tested out on a large scale among people in Europe and by our soldiers. We must have an open mind and give them a fair trial in postwar days. Some of the new foods now being made include:

A new yeast developed as a food and with no leavening power,[33] for which many recipes are already available. This is an excellent source of good quality protein and of B-complex vitamins and will be low in cost.

Menhaden fish[34] which are very bony and have not been accepted for this reason, are now being processed in a way that dissolves the bones. The product is being called silver herring and is very popular in England. It is inexpensive and has a flavor resembling salmon.

Various forms of new fish pastes are being made with nutritive value similar to oysters because of the incorporation of many of the internal organs of the fish used in their preparation.

Machinery has been developed for removing all juices and extractives from vegetables and

fruits by subjecting them to as much as 12,000 pounds pressure. The resultant extractive can be dried and compressed, with high keeping quality, nutritive value and flavor.

We are all familiar with some of the concentrated food bars being used so widely as emergency rations for combat troops. Who knows what use they will have in postwar days?

Egg shells are being pulverized so fine that the powder has no more grittiness than powdered sugar. This is now being put back into egg powder for lend-lease use by our soldiers where milk rations are low. It would be an excellent source of calcium.

The protein from waste wheat, a by-product of the manufacture of industrial alcohol, is now being canned for human use. There are many possibilities for its use and it should be a cheap source of protein.

HOT SPRINGS CONFERENCE

In conclusion plans were started at the United Nations Conference on Food and Agriculture held in Hot Springs, Virginia, May 18 to June 3, 1943, to take up where United Nations Relief and Rehabilitation Administration leaves off in efforts to improve the nutritional status of people in all nations. This work was started, as you all known, in the League of Nations. Delegates to the Hot Springs Conference[36] conferred and made recommendations for an Interim Commission which will determine upon a permanent type of organization. In the meantime this commission will seek to collect necessary information and suggest policies for carrying out, as soon as possible, the objectives agreed upon. All recognized that the first task was to WIN THE WAR. At the Hot Springs Conference the following three problems were considered by separate sections:

1. What are the needs of peoples of the world for foods essential for health and for other agricultural products?
2. What are the prospects for organization of world agricultural production so as to expand it and better direct it for supplying world food needs?
3. How can increased production be distributed to meet human requirements everywhere?

The primary concept of the conference was that each nation has the responsibility for seeing that its own people have the food needed for life and health; that steps to this end are for national determination; but that each nation can fully achieve its goal only if all work together.

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Interesting Side-Lights on the Epilepsies

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THE frequency with which one meets petit mal attacks presenting "blackouts", "trance states", etc., and an occasional grand mal seizure associated with a definite syndrome of hypoglycemia, merits our consideration and interest.

Depending on the degree and duration of the hypoglycemia, the rapidity with which the blood sugar has fallen, the production of symptoms varying from weakness, trembling, profuse perspiration, chilliness, tacchycardia, visual disturbance, confusion, drowsiness, disorientation, peculiar distressing feeling in the epigastrium, to more profund symptoms of cerebral origin such as amnesia, temporary paralysis, tonic, clonic convulsions, coma and death make their appearance.

Many of these states are diagnosed intracranial diseases, often times as epilepsy proper or brain tumor.

In 1924 Harris proposed hyper-insulinism, later this was confirmed by Wilder and others in 1927.

I cannot believe that spontaneous hypoglycemia and hyper-insulinism are synonymous. Although quite difficult to diagnose at times, I believe this differentiation can be seen in the clinical symptoms presented by the cases I will report, their studies and subsequent progress.

CLASSIFICATION

Conn[1] has written much on this subject and proposes an etiologic classification of spontaneous hypoglycemia: 1. Organic Hyper-Insulinism. 2. Hepatic Disease. 3. Endocrine Disturbance. 4. Functional (no recognizable anatomic lesion).

One of the characteristics of spontaneous hypoglycemia is the extremely low levels of blood sugar encountered, the increased frequency of the attacks, the fact that an attack can be reproduced by a diet extremely low in carbohydrate and an interesting phenomena that many patients have learned to abort an attack by glass of orange juice or a piece of sugar.

I have seen a number of cases of what I regard as spontaneous hypoglycemia following an alcoholic debauch, two with blood-sugar as low as 40 mg. It is assumed they had eaten very little while on the prolonged spree. On entering the hospital they were in coma, state of tonic rigidity, with occasional fine fibrillary twitching throughout the musculature, one with prolonged generalized convulsive seizure, with conjugate deviation of eyes, corneal anesthesia and positive Babinski, who responded in a few minutes to an intravenous injection of dextrose. Since no apparent evidence of liver disease was uncovered in either of them, it is fair to assume that with diminished food intake, spotty eating, depletion of liver glycogen may well have been a factor in producing a spontaneous hypoglycemia, plus a toxic factor in alcohol.

I recall a bartender, who as a steady consumer of alcohol had learned to abort an oncoming coma with a glass of orange juice, failed one day in preventing a coma, entered the hospital comatose, blood sugar 25 mg. A thorough study failed to reveal any existing pathologic condition. With the use of a high protein diet and elimination of alcohol, he now for more than three years has been free from any such attacks.

HEPATIC ORIGIN

CASE I

White male, age 50, for 10 years had fainting attacks daily. After one year they became nocturnal and were attended with psychotic behavior, screaming and yelling, with automatic manifestations. Amnesia for such conduct prevailed. Five years ago, attacks occurred biweekly, with profuse sweating of face and hands, cloudy sensorium, coma interspersed with an occasional grand mal seizure. Developed memory disturbance, occasional confusion, was forced to give up a responsible position. Owing to insight and loss of security, he was much disturbed by the consciousness of an attack.

Neurologic examination was negative throughout. Tenderness over right upper quadrant was disclosed. Sugar tolerance, fasting 70 mg; first hour 80 mg; second hour 80 mg; fourth hour 70 mg. B.M.R.—10%. Other laboratory and X-ray of gall bladder was essentially negative.

Cholecystectomy over one year ago, he has since been free from attacks. Sugar tolerance two months ago, fasting 90 mg; first hour 145 mg; third hour 100 mg; fourth hour 95 mg.

Submitted May 4, 1944.

The Author

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CASE II

Male, age 45. For three years had bi-weekly attacks of loss of consciousness, monthly severe grand mal seizures, attacks initiated with profuse perspiration, drowsiness and confusion. Minor attacks would occur with pallor, disorientation and momentary confusion. Amnesia existed for all attacks. A diagnosis had been made of an expanding intra-cranial lesion.

Neurologic examination was essentially negative. Palpation over abdomen revealed tenderness over mid epigastrium. Gastric analysis was normal. Fasting blood sugar 70 mg; first hour 80 mg; third hour 65 mg; fourth hour 40 mg; six hours after meal low in carbohydrates, patient became confused, profuse perspiration over hands, face and body developed. He was revived by a glass of orange juice. Icterus index 9; B.M.R.—5%. X-ray skull negative. X-ray gall bladder revealed a large cloudy gall bladder with suspected stone.

Cholecystectomy was done, several stones found in gall bladder. Pancreas examined and found normal. No other pathology found in abdomen. Now for over two years patient has been free from attacks. About one year ago, fasting blood sugar 82 mg; first hour 130 mg; fourth hour 80 mg.

ENDOCRINE GROUP

CASE III

Female, age 20. Uninteresting family history. Since 12 years of age, has had five petit mal attacks daily of which her parents had no knowledge until recently. Menstruation at 11, bears no relation to attacks.

Neurologic examination and physical examination essentially negative. Electro-encephalogram shows diffuse abnormality without any evidence of focal cortical change. Has a very low threshold of explosion. X-ray of skull negative; sella is flat, oval, rather small with moderate heavy clinoid process. N.P.N. 27; urea 11. Blood sugar fasting 80 mg; second hour 80 mg; fourth hour 70 mg; chlorides 581 mg; blood cholesterol 132 mg; icterus index 6. Bromosulpthalein retains 95% after 30 minutes. Spinal fluid. Total protein 57 mg. B.M.R. —15%. Radiograph gall bladder negative. Under high protein diet, taking thyroid gr VI daily, without exhibiting any signs of intolerance, there has been a gain of 50 pounds in weight, attacks have ceased to about two "blackouts" monthly. She appears brighter and is progressing in her work.

CASE IV

Female, age 16. For over one year had weekly diurnal attacks occurring with greater frequency in morning, with bi-monthly nocturnal attacks (grand mal). If breakfast was delayed, would act silly, grow nervous and exhibit psychotic behavior, which would disappear after eating. Menstruation established at 12, regular, bears no relation to attacks. Neurologic and physical examination are negative. Icterus index 6. Blood cholesterol 170 mg. Bromosulphthalein 90% retained after 30 minutes. Fasting blood sugar 70 mg; first hour 80 mg; third hour 85 mg; fourth hour 50 mg. Under large doses of thyroid daily and high protein diet over one year has been free from attacks and has gained 25 pounds in weight.

CASE V

Female, age 20. Jaundice as a child. For two years had nocturnal attacks, taking the form of weird dreams which she would carry over into the morning, awakening terrified, several times daily had "blackouts", attended with blank staring for several seconds duration, irregular in number, would tremble, grow pale, perspire profusely for two or three minutes. Again was frequently lost on the street. Attacks sometime terminate in nausea and vomiting. On one occasion had severe grand mal seizure, was thrown to floor, severely injuring tongue. Marked loss of weight, maintains apprehensive attitude regarding dreams, but is amnesic for attacks. Neurological examination fails to disclose any evidence of focal intracranial disease. Physical examination negative except for tenderness over epigastrium which has existed for few years. X-ray of gall bladder is negative. X-ray of sella reveals no abnormality. Icterus index 5.5. No bromosulphthalein after 30 minutes. Gastric analysis negative. B.M.R. —14%. Sugar tolerance fasting 80 mg; first hour 82 mg; third hour 90 mg; fourth hour 70 mg. Following an attack blood sugar level reached as low as 40 mg. After 10 months on large doses of thyroid and high protein diet, eating regular, patient has freedom from attacks, no weight change, with marked improvement in morale.

CASE VI

Female, married, age 26. About four years ago, while walking on street, suddenly had a "blackout" lasting few seconds, grew markedly apprehensive, able to return to her home, trembling with tacchycardia. Since that time averages three to four such attacks daily, frequently attacks are nocturnal with sphincter disturbance. On one occasion had peculiar sympathetic phenomena in which one half of body was covered with profuse perspiration, grows panicky at times fearing return of attacks. Diet, as in all of these cases, was spotty, had intervals of 16 hours without food of any substantial value. There has been a loss of 30 pounds in weight since onset of these attacks. Neurologic examination was negative except for hyperactive reflexes throughout, prominent manifestations of vagatonia was observed. Physical examination reveals tacchycardia, arrythmia and extra systoles, many teeth are missing, evidence of calcium deficiency is seen. X-ray gall bladder—normal in size but dense shadows are seen. X-ray sella—normal in outline and size. B.M.R. —15%. Blood calcium 6 mg. Sugar tolerance first hour 80 mg; second hour 88 mg; fourth hour 70 mg. A tray extremely low in carbohydrate produced profuse nausea and perspiration with marked acceleration of heart action, which condition was relieved by glass of orange juice in a few minutes. At time of attack blood sugar level was 30 mg.

Under high protein diet, thyroid and large doses of calcium, it has now been over 18 months since an attack has occurred. In addition patient shows a gain in weight of over 40 pounds. Her general health is much improved and she appears more stabilized emotionally.

This case is one of a fairly large number presenting evidence of a disturbance of the autonomic nervous system, appearing more noticeable than any of the preceding cases.

CONCLUSIONS

It would appear that of the cases mentioned, all with the exception of Cases 3 and 4 fall into the Endocrine Group, and while the metabolic rate is not very low, the changes seen in

metabolism exhibited by the increase in weight and improved morale following treatment would tend to substantiate, I think, the etiologic factor.

In none of the above cases has renal glycosuria been seen.

In Cases 5 and 6, the frequency of attacks were increased by the use of a high carbohydrate diet and also by a high fat diet and were corrected by the use of a high protein diet.

It would appear that the latter diet is of advantage in the treatment of this type of case, because of the slow rate at which glucose is liberated during metabolism. Fifty per cent of the yield during metabolism of protein is dextrose.[1]

Investigations show that the complete action of the adrenal sympathetic nervous system is necessary for maintenance of a normal blood-sugar level. If for some reason the mechanism fails or is altered, the thyroid gland compensates for such failure by increasing its functional activity, increasing and elevating metabolism.

A meal high in carbohydrate before retiring will frequently control the hypoglycemia found before breakfast. This was applied in Case 4 and proved successful and I have seen it effective in other cases of this type.

Since many of the above related attacks are miniature states of what we see in patients under insulin therapy as applied in the treatment of the psychoses, we naturally are curious as to what goes on in the brain during this condition.

Up to the present time, investigations do not with any degree of certainty give us the exact patho-physiologic state of the brain during insulin hypoglycemia. We of course know the vulnerability of the brain to lack of either dextrose or oxygen and that the chief foodstuff of the brain is carbohydrate. When the brain is deprived of carbohydrate, cerebral metabolism is necessarily depressed, with resulting changes in its function. The effect of a short period of hypoglycemia is readily reversible by the administration of carbohydrate, when it is prolonged, repeatedly, cerebral damage may occur with irreversible degeneration of brain tissue and cells, resulting in slow recovery or even in permanent functional damage.

These cases are of extreme importance because they tend to indicate the borderline in the reversibility of the cerebral changes. I know of only one case in my experience, alive, but handicapped by a distinct neurological and psychiatric disability. Baker[2] reports four such cases.

The same is applied when oxygen is not available for the utilization of dextrose. The symptoms of anoxia resemble those of hypoglycemia. When of short duration, the symptoms are entirely reversible, when more prolonged permanent cerebral damage may result. Different parts of the brain vary in susceptibility to injury when metabolism is depressed in this manner by hypoglycemia or anoxia. Those phylogenetically new are the first to suffer changes.

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Filariasis

The diagnosis of filarial infection can be accomplished in most cases by examining the patient's nocturnal blood microscopically for the presence of microfilariae. Either fresh blood or a properly stained thick blood film can be used for the examination, the organisms being easily detected under a magnification of one hundred diameters. Still another method is to examine a concentrate of a larger volume (10 cubic centimeters) of blood, the blood cells first being lysed by saponin or other hemolytic substance, the solution then being centrifugalized, and the resulting sediment finally being examined for the presence of the microfilariae.

In persons who show symptoms of elephantiasis, on the other hand, microfilariae seldom occur in the blood. The diagnosis of filariasis in these persons is much more difficult and usually rests, finally, either on the study pathologically of sections prepared from an excised enlarged lymph node or else on immunological tests. Antibody specific for the filaria antigens appears in the blood of patients and can be detected by the complement fixation technic. A simpler diagnostic procedure, which also rests on an immunological basis, is the skin test. When a small quantity of filaria antigen is put into the skin of a patient with filariasis, an allergic type of reaction, characterized by a wheal with pseudopodia, occurs in from five to ten minutes.

The great barrier to the wider utilization of the immunological tests is the difficulty in procuring antigen. The human filarial worms—either adults or microfilariae—represent the logical source of antigen. Adult specimens, however, are almost impossible to procure and comparatively large quantities of blood from intensely infected patients would yield enough microfilariae for but few tests. Hence, the natural filariae of certain animals, which can be procured with comparative ease, have been tried for these immunological tests and have been found to serve admirably. Adult filarial worms from the heart lumen of the dog and from the pleural space of cotton rats have been used successfully.—James T. Culbertson, Ph.D., New York City. American Jr. of Nursing. Vol. 44, No. 7, July, 1944.

Catarrhal Jaundice: Epidemic Hepatitis

ROBERT G. LEHMAN, M.D.

JAUNDICE of obscure origin and epidemic type has occurred in every war among participating troops and the present world conflict has not proved to be an exception.[10,14] Numerous reports of the occurrence of icterus of this character have been received from the armed forces of the belligerent nations since the war began. Since these epidemics resemble the disease familiarly known as "catarrhal jaundice", attention has become focused upon this disease.[1,8,10,14]

Since the pathologic studies of Eppinger[29,34] and other more recent ones,[10] it is known that the essential pathologic change in catarrhal jaundice is not a duodenitis with obstruction of the common bile duct by a mucous plug, but rather an acute inflammatory process in the liver, a result of which is the inability of the sick liver cells to excrete bilirubin brought to them from the reticulo-endothelial system. By virtue of this concept, a more accurate diagnostic designation for catarrhal jaundice is "epidemic hepatitis"[1,8], for as Bloomfield[9] has pointed out, "Acute hepatitis . . . seems a better term than catarrhal jaundice . . . and preserves the analogy with obscure disease of other organs, such as nephritis . . ."

INCIDENCE

Epidemic hepatitis has occurred among English civilians,[11,12] among the British armies in the Middle East,[13,15] among German troops in the occupied territories,[16] the German African Corps,[10] and among American forces in the South Pacific area.[17] Analysis of these numerous epidemics reveals a striking clinical similarity to, if not an actual identity with catarrhal jaundice.

In addition to the occurrences of epidemic hepatitis which have been cited, another variety of jaundice with similar clinical characteristics, has been reported. This second form has occurred both in American and British armed forces and in Brazil and has come to be known as "homologous serum jaundice."[2,3,18,20] The most widespread occurrence of this type of jaundice was after vaccination against yellow fever; icterus of this variety has been termed "postvaccinal hepatitis."[3,10,18,21,22]

Approximately 28,000 cases of postvaccinal hepatitis with 62 deaths occurred in U.S. Army personnel during the first six months of 1942.[10] The clinical course of the disease resembled epidemic hepatitis of unknown etiology, although most cases of postinoculation jaundice were more severe and fatalities were commoner.[3,10] A similar sequence of events took place in Brazil in 1939, where one lot of yellow fever vaccine was followed by an attack rate of 27 per cent.[18,21] The elimination of pooled human serum in the manufacture of the vaccine prevented the recurrence of jaundice.[10,18] Likewise, the Army has had no new cases since the use of the human serum component of the vaccine was discontinued.[10]

Experiments conducted in the Virgin Islands in 1942 on individuals who had developed postvaccinal hepatitis following inoculation against yellow fever, revealed that approximately 15 per cent of vaccinated individuals were affected. The incubation period varied between 75 and 130 days. No contact case occurred. Hepatitis was produced in 24 per cent of volunteers by inoculating them with the same lot of vaccine. The icterogenic agent was found to be present in the human serum component of the vaccine. This agent was found to be filterable, to survive drying in a vacuum, storing for long periods in serum at 4 C. and heating in the dried state for 30 minutes. It was inactivated by ultraviolet irradiation. Serum taken from an individual 75 days after hepatitis had subsided, had lost its ability to transmit hepatitis. Evidence was obtained that the jaundice-producing factor was present in the blood before icterus appeared.[19]

Findlay and Martin[22] conducted experiments in transmission of the icterogenic agent in postvaccinal hepatitis. They obtained nasal washings from 3 patients in the pre-icteric stage of postinoculation jaundice and instilled these washings into the nares of 3 healthy volunteers. The latter developed hepatitis after incubation periods varying from 28 to 50 days. There was considerable variation in the severity of the illnesses of these recipients, but the symptoms were similar to those of epidemic hepatitis.

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Clinical syndromes identical with those of epidemic hepatitis have followed the use of convalescent serums[2,18] and have occurred after transfusion.[18,23,25] Among 75 English children who received measles convalescent serum from the same batch, 18 developed jaundice after 16 to 114 days and 4 died of hepatic necrosis.[18] Of 266 British troops who had been given pooled mumps convalescent serum, 86 developed jaundice. Of 36 patients treated for peripheral vascular disease with reconstituted dried human serum, 8 developed icterus.[18]

Medical officers of the British Ministry of Health concluded that hepatitis following transfusion as well as convalescent serum hepatitis, is indistinguishable from catarrhal jaundice (epidemic hepatitis) and postvaccinal jaundice.[18] The jaundice which frequently occurs during arsenotherapy resembles epidemic hepatitis and there is increasing evidence that there may be a common etiologic agent in all these acute hepatopathies.[26,28]

PATHOLOGY

Various authors[9,29] have asserted that the epidemic hepatitis is not a distinct pathologic entity but rather a group of diseases. It is well known that a variety of noxious agents is capable of causing acute hepatic necrosis: ". . . chemicals, drugs, foreign proteins and products of protein decomposition, bacterial toxins and infections . . ."[29] A corollary is seen in cirrhosis (chronic hepatitis), in which chemical, physical and biologic agents produce the same pathologic change, fibrosis.[29] Thus, the capacity of the liver to respond to acute injury is apparently as limited as its ability to respond to chronic; necrosis is the acute counterpart of fibrosis.

Eppinger established that the commonest variety of epidemic hepatitis was due to hepatocellular damage[29,34] and he believed that catarrhal jaundice was "acute yellow atrophy in miniature," a view shared by other authors.[29,34,35] Histologic examination of tissue obtained during the first ten days of postvaccinal hepatitis showed acute inflammation of the liver unassociated with any form of common bile duct obstruction; the chief pathologic lesions were those of an acute or subacute yellow atrophy.[10] Aspiration biopsies done by various investigators[26,28] have revealed hepatic cell necrosis irrespective of whether the patient was suffering from epidemic hepatitis, homologous serum jaundice or hepatitis occurring during arsenotherapy. The clinical identity of these hepatopathies is thus supported by their pathologic identity.

The chief distinction between epidemic hepatitis and the other acute inflammatory conditions of the liver under consideration, is on epidemiologic grounds.[3]

(a) The incubation period of epidemic hepatitis is 20 to 40 days; that of homologous serum jaundice 60 to 120 days.

(b) Patients with catharrhal jaundice are infectious during the pre-icteric stage and for a few days after jaundice appears;[22] however, infections acquired after simple exposure to homologous serum jaundice are extremely unusual.[2,3,10,18]

A recent editorial[3] gives several possible explanations for homologous serum jaundice:

(a) The infected serum may contain a virus capable of producing hepatitis in the homologous species.

(b) The type of bodily reaction may be changed because of the fact that the infection is acquired after subcutaneous inoculation rather than by the nasopharyngeal route, which is the natural one for epidemic hepatitis.[3,6]

(c) Some toxic agent may be introduced in the process of preparing the immunizing material.

(d) The homologous serum is altered in the process of preparation in such a way that it becomes antigenic and capable of producing antibodies which react with newly manufactured proteins in the liver, thus causing an inflammatory antigen-antibody reaction.[3]

How human blood products may acquire transmissible icterogenic properties requires further investigation.[2,18,19] It appears highly probable that further cases of homologous serum jaundice are bound to occur from the use of convalescent human serum and especially after transfusion.[2,18,23]

The evidence that the etiologic agent in epidemic hepatitis and the allied hepatopathies is a virus, seems to be weighty. The experiments of Findlay and Martin[22] and of the investigators of the National Institute of Health[19] all point in such a direction. The clinical identity of these diseases is supported by their pathologic identity. The essential pathologic change in all is **necrosis**, as has been demonstrated. Acute necrosis is frequently the pathologic change characteristic of a virus infection[36] and these observations, together with the facts that there is a prolonged incubation period and a leucopenia in epidemic hepatitis, support the assumption that the disease is caused by a virus, spread in all probability by way of the respiratory tract. Beckman,[30] Watson,[31] Snell[32] and Magath[33] share this opinion.

The clinical characteristics and differential

diagnosis of epidemic hepatitis have been thoroughly described in the references cited and will not be reiterated here.

PROGNOSIS

Although most of the evidence to date suggests that the liver is not permanently damaged as the result of epidemic hepatitis,[10,14,17] some authors insist that the incidence of cirrhosis is higher in those who have suffered from epidemic hepatitis than in the general population.[29,35] Both Boyd[29] and Beckman[30] cite the studies of Soffer and Paulson (1934), which indicated that permanent impairment of hepatic function may occur more often than suspected. Recent studies of 200 soldiers who had jaundice due to postvaccinal hepatitis, revealed that a number showed evidence of hepatocellular dysfunction as long as 6 to 12 months after the initial attack of hepatitis.[37] It seems probable that residual liver damage depends upon the severity of the original inflammatory process in the liver.[1,10,18]

THERAPY

The treatment of choice in epidemic hepatitis consists of the daily administration of a diet high in carbohydrate (500 grams) and protein (100 grams) and low in fat (50 grams or less). This diet should be reinforced when indicated by the intravenous administration of dextrose and plasma and perhaps by protein hydrolysate when the latter becomes more widely available. Supplementing this diet with the liberal use of vitamins, especially the B complex, is indicated. The use of choline and methionine in protecting the liver is still experimental although the results are promising. Complete bed rest is essential until hyperbilirubinemia is absent and it has proved unwise to allow the patient ambulatory privileges unless the icterus index is less than 20 units.[10,17]

SUMMARY

1. The disease commonly known as "catarrhal jaundice" is more accurately termed "epidemic hepatitis."

2. Epidemic hepatitis has occurred in almost every great war and its occurrence has been widespread during the present conflict.

3. Pathologic studies in this disease indicate that the essential histologic change is necrosis. Duodenitis and obstruction of the common bile duct do not occur.

4. Epidemic hepatitis is allied to if not actually identical with homologous serum jaundice and hepatitis occurring during arsenotherapy.

5. The etiologic factor in this disease remains unknown but substantial evidence indicates that it is a virus infection spread by droplet mode.

6. The degree of permanent liver damage resulting from epidemic hepatitis is dependent upon the severity of the initial inflammatory process within the liver.

7. Essentials in the therapy of this disease have been outlined.

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Occupational Anemias*

KARL V. KITZMILLER, M.D., and ROBERT A. KEHOE, M.D.

OCCUPATIONAL anemias may be defined as a specific group of "toxic" anemias that result from the exposure of workmen to compounds capable of exerting an injurious effect on one or more components of the hematopoietic system.

As a result of the greatly accelerated tempo of present-day industrial activity in war production, a great number and variety of compounds are being manufactured or used that have known or suspected adverse effects upon the blood or blood-forming organs. Among the most important of these are the aromatic, chlorinated, and methylated hydrocarbons such as tetrachlorethane, trichlorethylene, benzene (benzol), toluene, xylene, chlorobenzene, gasoline, benzine, and naphtha, and the aromatic nitro-amino compounds and their methyl derivatives, notably aniline, xylidine, toluidine, and diamino-xylidine.

Also included in this list are lead, phosphorus, radium and other radioactive elements, arsenic, arsine, and a host of new compounds that almost daily are finding industrial usage despite the fact that little or nothing is known of their dyshematopoietic properties.

Any comprehensive study of occupational anemias should include a review of the experimental and clinical observations relating to disorders of the blood induced by specific chemical agents, a survey of the working environment with particular attention to the adequacy of hygienic measures designed to control or eliminate significant exposures to these agents, and comprehensive hematological examinations of comparable groups of exposed and unexposed workmen. The latter must be included as a basis for comparison in order to evaluate the significance of non-specific variations in the blood picture.

Information should also be available on the past and present state of health of the individual workers, the nature of their home surroundings, recreational facilities, and state of nutrition, with special emphasis on the amount and quality of their food and of its vitamin content, since these factors may play an important role in development of any type of anemia.

THE DATA

In any instance of specific industrial hazard it will be necessary also to have as much information as possible concerning the etiology of the occupational anemia and its relationship to exposure, in determining whether or not the manifestations come on immediately or are delayed for a short period. It is also desirable to have information concerning the effects of prolonged or continued exposure. An attempt should be made to place the anemia in a precise hematological classification because of the important bearing this may have on adequate treatment.

While anemia is the primary consideration of this review, a study of the complete blood picture and of the entire hematopoietic system as well should be undertaken because of the necessity of having all possible data available for proper classification, study, and therapy, and also of excluding non-occupational causes for anemia such as vitamin difficiencies and nutritional disturbances, gastro-enteric and liver disease, hemolytic jaundice, pernicious anemia, leukemia, malignancy, chronic nephritis, parasitic infestation, and concealed hemorrhage from unknown causes.

THE WORK-UP

The following procedures constitute the essentials of an hematological work-up of this type: frequently repeated and accurate blood counts including erythrocyte, stippled erythrocyte, leucocyte, reticulocyte, platelet and differential counts, and hemoglobin estimation by an accurate method frequently checked by one of the gaso-

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metric techniques or total blood-iron determinations.

Particular emphasis is placed on the necessity for accurate erythrocyte counts and hemoglobin determinations, for they, together with hematocrit estimations, form the basis for calculating the corpuscular constants which have come to occupy a most important place in the hematological classification of anemia. These consist of mean corpuscular volume, mean corpuscular hemoglobin, and mean corpuscular hemoglobin concentration, and offer the greatest aid in a study of occupational anemia because they serve to classify it as macrocytic, microcytic, hyper- or hypro-chromic, and thus indicate the nature of the action of the injurious agent.

Although most industrial anemias are of the so-called toxic, hemolytic, or microcytic type, a significant number are macrocytic and these may occur as the result of some stomach or liver disorder caused by an industrial exposure which interferes with the elaboration or utilization of the erythrocytic maturation factor.

The presence of macrocytosis with little or no depression in the erythrocyte levels may also point to some toxic functional liver disorder which may then be investigated by suitable liver function tests.

Other important essentials in the study of the blood are sedimentation time, bilirubin content or icterus index, red-cell fragility, clot retraction, coagulation, bleeding and prothrombin time, and study of the sternal bone marrow when indicated in the more severe types of hematopoietic disorder. In examination of the blood film particular attention should be given to the presence of basophilic stippling, polychromatophilia, variation in the shape and size of the red cells, presence of erythroblasts, normoblasts, myeloblasts, myelocytes or other primitive forms, or any unusual variation in the percentage distribution of the white blood cells.

In this respect the presence of a relative lymphocytosis with or without leucopenia and frequently with reversal of the normal leucocyte-lymphocyte ratio has been regarded as a sign of early intoxication following exposure to benzol and complex solvents (composed chiefly of hydrocarbon mixtures, chloro compounds, ethyl acetate and carbon tetrachloride), and may well have the same significance in other instances when little or no information is available on the toxicological properties of the compound involved. It seems that this phenomenon is related in some fashion to irritation of the reticulo-endothelial system and deserves close scrutiny in any instance of suspected hematological intoxication.

SUMMARY

It is obvious from this general review that the proper study of the blood in relation to industrial toxicologic exposure constitutes a task of considerable scope and should not be entered into lightly by the industrial physician. Cursory examinations by indifferently trained or careless technicians with inadequate facilities and methods and without adequate controls are valueless and may be harmful. Results obtained from careful work in the hands of a physician capable of interpreting them in the light of the clinical and toxicologic aspects of the problem as a whole will go far toward safeguarding the health of workmen and in placing this field of industrial medicine in its proper sphere of usefulness.

Diagnosis of Primary Bronchiogenic Carcinoma

The diagnosis of bronchiogenic carcinoma is generally not difficult if one will only consider the possibility of its existence. As mentioned above, it should be suspected in every case, particularly in a male past forty years of age who has an unexplained respiratory or digestive complaint. In the past undoubtedly most pulmonary carcinomas have been incorrectly diagnosed. Sehrt, in 1904, reported only 3.3 per cent of antemortem diagnoses in a series of 178 cases. Careful roentgenograms may show nothing. The roentgenographic interpretation of centrally located lesions is generally more difficult because of the confusion with hilar shadows produced by other lesions and by normal structures. This is particularly significant because most of the pulmonary neoplasms occur in the hilar region. The roentgenographic film may show a shadow produced by the tumor itself, a shadow produced by metastatic mediastinal nodes, or a shadow produced by an atelectatic lung. Occasionally, a very small peripherally located tumor, insufficiently large enough to cast a shadow, will give rise to a large mediastinal mass which may be considered the primary tumor.

Whereas roentgenographic visualization of the tumor or changes produced by the tumor are of importance in suspecting and diagnosing a bronchiogenic neoplasm bronchoscopic visualization of the tumor is particularly important and valuable. Not only does bronchoscopy permit the visualization of the growth in a high percentage of cases, but it also permits the obtaining of a piece of tissue for histologic examination. Unfortunately, bronchoscopy is not performed often enough.—Alton Ochsner, M.D., L. Leonard Dixon, M.D., and Michael Debakey, M.D., New Orleans. The Miss. Doctor. Vol. 22, No. 2, July, 1944.

Current Thinking in Nutrition

JONATHAN FORMAN, B.A., M.D., F.A.C.A.

WE have made a report to the readers of this *Journal* on the content of the program of each of the Annual Conservation, Nutrition, Health Conferences, as they have been held. The laboratory had been moved this year from Tar Hollow to the camp beside the lake at Leesville. In this enlarged and beautiful setting gathered nearly 200 distinguished authorities and students in the fields of nutrition, conservation, economics, health and science of living. We are happy to report that each year more physicians come to these conferences.

The visitors came from New Hampshire, Massachusetts, Rhode Island, Connecticut, Long Island, New York City, Washington, D. C., Philadelphia, Baltimore, Milwaukee, Ann Arbor, Detroit, Chicago, Iowa City, St. Louis, Columbia (Missouri), Memphis, Indianapolis, and from many places throughout the state. They came to listen, to discuss, and to learn. They learned that our health is primarily dependent upon our nutrition; that the state of our nutrition is directly dependent upon the quality of our food; that the quality of our food is dependent upon the soil in which it is grown; that the fertility of the soil and its nutritive qualities depend upon the amount of humus and the minerals which it contains. A very high percentage of all life is made out of air, water, and sunshine. The sunshine and the air come to the plant. Water must be provided, so that it too can flow to the plant. But the plant must send its roots after the minerals. And so, the water and minerals in the soil determine the health and strength of those men and animals who live upon that soil.

THE WATER PROBLEM

It is fitting, therefore, that each year these programs open with a discussion of some phase of the problem of our water supply. In Ohio we have been getting less and less of our rain water into the underground passages, as we go on we are coming nearer and nearer to making a desert out of our state. We learned at the conference last year of the important role that cover crops can play in directing raindrops into our sweet water table.

This year David C. Warner, known to almost every citizen in Ohio for his life-long fight for water conservation, discussed the impounding of water. He emphasized the importance of impounding directly into the fields through cover crops, of impounding in the uplands, through farm ponds and check-dams, and, finally, he pointed out the great advantages that would accrue to our state from the development of hydro-electric power from steam plants situated just below and utilizing large dams on our main rivers. The power that could be developed would readily amortize the cost. Furthermore, it would offer decentralized employment and part-time work for the people of Southeastern Ohio, so that not only would the population of these counties be stabilized, but the people might even be induced to return to them.

It was emphasized again that, if we could save two-elevenths of our run-off water, all human and industrial needs of the state would be taken care of adequately. In addition to the improvement of living standards in our sub-marginal counties through a program that would pay for itself, this plan offers much in the way of flood control and out-of-door recreation.

LAND USE AND ABUSE

Dr. William Van Dersal, author of "American Land," presented the story of how we have used and abused this land of ours from the days of Christopher Columbus to those of Hugh Bennett. After presenting the capacities of American land, he pointed out the two great discoveries upon which our civilization is founded—the first of these—lost in the long distant past, was that of the man or men who found out that, if you save the seeds of plants and put them in the ground the following year, they will grow and multiply. Much later, of course, came the discovery of the wheel.

Dr. Van Dersal explained how it came about that each generation has abused our soil more than the preceding. By a brilliant selection of quotations, from the writings of the early New England preachers, from Colonial leaders, from General Washington, Thomas Jefferson and on through the decades, up to the Friends of the Land, present at this conference, he showed how each of these, decade by decade, for the last 150 years, has warned that something must be done, but only in the last ten years has that something been done. He then summarized the work that had been started and showed how the utilization of the twelve simple soil conservation practices has increased the yields by more than 20 per cent on the average.

Dr. Paul Sears of Oberlin College, who is chairman of the Advisory Committee of the Ohio Conservation Laboratory for Teachers, gave

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A report of the proceedings of the Third Annual Conference on Conservation, Nutrition and Health at the Ohio Conservation Laboratory for Teachers co-sponsored by the Division of Conservation and Natural Resources, the State Department of Education, The Ohio State University, and the Friends of the Land, June 24-25, 1944.

a stimulating talk on "Man and the Landscape". Dr. Sears has the distinction of making best sellers of the stories of soil conservation on two occasions. The better known of these is "Deserts on the March". In this talk he presented a very simple thesis dealing with man and his surroundings. It was that the relationship between the resources of a country and the size of its population determines the way the people live—or what is commonly called their culture. Ohio, he pointed out, was badly overcrowded by 12,000 Indians. Consequently, they were constantly warring for "living room". These Indians were much more crowded with their method of living than we are now with our 7,000,000 people within the same area.

As the fertility is drained and mined from our soil, we too must adapt ourselves to a changed situation. We must correct our mistakes. "We can no longer gamble with our natural wealth, the situation is too critical." He pleaded for the unification of government agencies which confuse and baffle the farmer. Dr. Sears has been throwing out the challenge of late to the country banker to take his old and respected place as financial advisor to the people of the country-side.

Then came the highlight in terms of human interest when C. D. Blubaugh of Danville, Ohio, told the simple story of how an insurance agent with very limited funds bought one of the worst run-down hill farms in the state. For ten years he merely practiced scientific farming; for the last eleven years, however, he has added the fundamental practices of soil conservation, and now has one of the finest farms in the United States—an opinion asserted by Louis Bromfield and attested to by all farm experts who have visited this farm. From a farm producing practically nothing it is now yielding a net annual income of more than $15,000. From being unable to support one family, it now supplies with the best of food three families and their livestock and fowls.

This is the simple story of a man and his family who were willing to work, and what is just as important, were willing to do just as the experts of the University, the Extension and Soil Conservation Services advised them to do. All our citizens should have an appreciation of just what this man has done and how he has been able to do it. Such an understanding would do much to curb a headlong blind rush of our men to the farm when they return from the wars.

RURAL LIFE

Ralph Borsodi, the well-known economist and writer on the science of living, presented "a plan for rural life". This was, in fact, a plan for living. Dr. Borsodi along with many of us looks upon our cities as cancers upon society brought about through our inability to absorb into our economy **the machine.** He insisted that, if we are to plan for a sound culture, farming must become "a way of living for most of us instead of a way of making money for some of us". Dr. Forman pointed out in introducing Dr. Borsodi that there are a group of writers who are engaged in making an indictment of city life similar to this. It is so easy to do.

Dr. Albrecht, one of the speakers at the conference, had pointed out from his experimental studies that the very best way to determine whether the surroundings of an animal are good or bad for it is to determine whether or not that animal can maintain its population level under these circumstances. This is the major indictment against city life, since 100 city dwellers produced only 73 children who live and grow up. Of course, there are other counts against it. People die at a greater rate in the city than they do in the country. Many people's nerves are shattered by the noise. The rate of insanity is consequently higher.

There are other reasons for this. One of the most important is the greater number of frustrations which occur to the city dweller. Frustrations come at every corner. In the country, such things are or much less frequent occurence. There, one has the chance to live alone, or at least to be alone for a few hours now and then. In addition to the crowding, the hustle, and the disappointment in the city, there is also the great damage done to health by overcrowding, by the motor gasses and acid fumes in the air and by the smoke and smog which blot out the sun.

SOIL MINERALS

Professor Neville of the Long Island Agricultural Institute, who, by the way, is enrolled at the Laboratory this year, gave a fine demonstration of soil testing and its interpretation. He stressed that its techniques are much like our Wassermann and skin tests. Their value depends upon the skill and experience of the analyst.

Dr. Clyde Jones of the Ohio State University showed how plants build themselves out of air, water, and sunshine with the help of 20 minerals. With plenty of minerals to work with these plants can build cells rich in protein, producing soft, succulent vegetables which the experienced palate recognizes as superior both in taste and nutrient qualities. When the minerals are scarce, the plant cells are woody and tough. All but the most careless recognize that such vegetables are not "good".

At each of the Conferences, there has been a discussion of the role of calcium as a soil nutrient, as a catalytic agent involved in the production of amino-acids within the plant cells, as well as its importance in human physiology.

As climax to these discussions Dr. J. D. Boyd, Professor of Diseases of Children at the State University of Iowa, presented the results of his 20 years of study of tooth decay.

In the study he has had the complete cooperation of a distinguished group of dental teachers. The first became interested in the subject of tooth decay when he discovered that his diabetic children were not being troubled with tooth decay after their diets had been balanced. He then tried well-balanced menus rich in vitamins and minerals. Natural foods made up about 1,200 calories of the daily requirement. The rest of the needed energy was supplied by anything the child wished. Sugar, candy, pasteries and sweets could be eaten in quantity. It made no difference, so long as the essential elements were there.

Dr. Boyd therefore concludes that if one gets a sound, well-balanced, adequate supply of food, one will be strong and healthy and will resist disease. One does not need to worry about any disease, least of all about teeth. One can forget them. They will not decay. If they have already decayed, the adoption of such a dietary program will cause the tooth decay to stop.

NATIONAL NUTRITION

Dr. William A. Albrecht, Professor of Soils at the University of Missouri, gave one of his usual brilliant talks on "Soil Fertility and National Nutrition". He said "food is basic, of universal interest, and international concern. Food, furthermore, is fabricated fertility." He pointed out that within the plant carbohydrate compounds are built of air, water, and energy from the sun operating through the chlorophyll within the leaf. This fabrication is the great agricultural chemical industry that is agriculture itself.

Protein building is a constructive performance more deep-seated in the plant. Proteins are roughly carbohydrates into which nitrogen, phosphorus and sulphur have been chemically compounded. Just as potassium coming from the soil seems to act as a kind of carbohydrate catalyst, so calcium plays a catalystic role in the formation of protein. All life—plant and animal—analyzes about 5 per cent mineral. In other words, all living things are 95 per cent air, water, and sunshine and 5 per cent soil. Since the part from the soil furnishes us with our skeletons and the spark plugs (catalysts) for most of the vital processes in our bodies, soil fertility, or the ability to deliver the minerals is the greatest importance in all consideration of our national nutrition.

The mobilizing of soil fertility for plant nutrition and so indirectly for us, was graphically portrayed by Dr. Albrecht. The sunshine, the rain, and the water come to the growing plant, but the plant must send its roots down after the minerals. The hungry roots of the plant come in contact with the colloidal clay or the soil humus upon which are held the nutrient ions like calcium, magnesium, potassium, etc., in forms not removable by water but exchangeable by similarly charged ions. The clay colloids act as "food brokers," who can, from their stocks, offer quickly this absorbed supply of calcium, magnesium, and later the hydrogen, from the root surface in exchange. That is why an "exhausted" soil happens to be acid. It follows that the exhaustion is of significance, not the acidity per se.

Soils, Dr. Albrecht points out, are made by climatic forces. This accounts for an East and a West, as well as for the fact that our East long ago divided itself into a North and South. These natural divisions must not be ascribed to personal or political differences, but to the soil fertility produced by climate acting upon rock formations.

Plant health is dependent upon soil fertility, i.e., upon the availability of these essential minerals. Further nutrition for both plants and animals needs to look to clay soils and their essential mineral resources. Civilizations on sandy soil have always been short-lived. We in the United States need to take an inventory of our soils for their potentialities as to future nutritional service. We need to know how much we have in the way of mineral reserves. We are about to enter upon international responsibility which makes this knowledge imperative.

Fertility differs according to soils as they are in construction or destruction. This is the reason that alfalfa grows readily without good soil treatment in Kansas, Nebraska, Colorado, where there is less leaching and less destruction with more construction. Cotton grows in the red, more highly weathered soils of the South. It is these different levels of plant nutrients that brings about correspondingly different chemical composition of the crop and moves them from the category of animal forage feed in the case of alfalfa to those of no feed value in the case of cotton.

Fertile soils make proteinaceous, or "grow" foods of higher nutrient content. In fact, the crop composition can now be controlled experimentally by controlling the fertility of the soil.

Animals know all this. Wild animals have choices and their eating habits reflect delicate differences in soil fertility. The distribution of animals fits perfectly into the soil fertility pattern of the country. Even domestic animals can seem to assay the value of foods according to the fertility of the soils upon which they have been grown. Animal diseases, like plant diseases, cor-

relate themselves with nutrition in terms of soil fertility. Dr. Albrecht thus pictured the human population according to the pattern of soil fertility.

"We are learning to believe that we are as we eat in spirit and behavior as well as body form and stature. . . . Our life is built on the soil and our future life, as it is to be readjusted in global dimensions, dare scarcely disregard our soils in terms of their differences in fertility."

POST-WAR PLANS

"Design for post-war living" could have been the title of the Conference. Chester Davis, President of the St. Louis Federal Reserve Bank, was in attendance as president of Friends of the Land. who co-sponsored this Conference. He warned, "The fullest cooperation of everyone is essential if we are to avert catastrophic depression after the war. Start now to prepare for post-war readjustments. Provide for equal return and opportunities for farm and urban workers alike. After the war, we shall need 60 million less acres than are now in production to supply our domestic needs. And, since in the last analysis, the home market is always the best, it must be cultivated.

"Our programs of optimum nutrition through adequate food supplies must be pushed to a successful completion in order to build this market. For this reason, a full program of industrial production of useful things with the attendant full employment is of as great importance to the farmer as a prosperous farm populace is to the manufacturer and his employees. "Loans will have to be made and farm costs cut. Potential land booms will have to be curbed as well as any back-to-the-land rush among the returning service men. "Above all, we must develop healthy terms of land tenure and ownership of land should be regarded as a trust which no one should be allowed to abuse."

SUMMARY

At the end of the program, Dr. Jonathan Forman, who had much to do with arranging it, summarized the conference about as it has been reported here, with the addition however, that at the Conference we have been discussing health. Health is the opposite of sickness, to the relief of which we physicians have dedicated our lives.

Health is more than freedom from disease. It is freedom from oncoming disease. It is a positive bouyance which gives joy in living happiness, and long life. Such a blessing comes only through a sound nutrition. Dr. Forman called attention to the fact that the Wagner-Murray-Dingell Bill has nothing to do with health. It attempts to redistribute pills, potions and other medical services at the workers' expense through compulsory taxation, whereas sound nutrition, with a rational program of living would make all this unnecessary. He, therefore, pleaded for more thinking along the lines represented by the Conference of Conservation, Nutrition and Human Health.

Carcinoid Tumors

Malignancy.—Much debate has occurred regarding the question of when is a carcinoid benign and when malignant. Pathologists do not seem to agree, but it seems safe to say that all are potentially malignant and if allowed to grow long enough, they undoubtedly will break into and infiltrate the surrounding tissue. Where they go from there seems to vary in different individuals. The liver and regional nodes are the common locations for metastasis. For the most part, they seem to be a slow-growing tumor and, if producing obstruction, should be removed even in the presence of metastasis. Pennington and Pristley report a patient who was alive and in excellent health 19 months after palliative resection which was done in the presence of liver and peritoneal metastasis. This is the case we have previously mentioned in which there were 68 different tumors. Latimer mentions Mallory's patient who, with a portion of the ileum resected, lived 15 years to die of another cause. At autopsy, enlarged retroperitoneal glands were found which proved similar to the previously removed carcinoid. Porter and Whelan mention other similar cases, proving the slow-growing tendency of these tumors.

The incidence of metastasis in carcinoid of the appendix is reported by Uihlein and McDonald as less than 1 per cent in 127 cases. Pennington and Priestly summarized the literature using the combined figures of Cook and Ariel as follows. The total number of carcinoids of the small intestine was 237 in which obstructive symptoms occurred in 24.4 per cent, and metastatic lesions in 25 per cent.

Humphreys feels that the thread of malignancy is inherent and the low degree of malignancy in the appendix may be due to the early removal because of symptoms referable to the appendix. Not overlooking other possibilities, it seems that early removal of the appendix would certainly reduce the number of malignant carcinoids especially when their slow growing character is considered.

Pre-operative diagnosis is for most part impossible, but the possibility of malignancy should be thought of when a tumor is found in the appendix.—J. E. Blumgren, M.D., Duluth, Minn. Minnesota Medicine. Vol. 27, No. 8, August, 1944.

Cystic Fibrosis of the Pancreas*

RICHARD E. WOLF, M.D., and RALPH JOHANSMANN, M.D.

A THREE and one-half year old white boy (Case 38780) entered the Children's Hospital on March 28, 1943, and was admitted to the service of Dr. L. K. Felter, with a long standing history of cough, "peculiar stools" and inability to gain weight.

Past History: The child was born after a term period of gestation and a normal delivery. The birth weight was six pounds seven ounces; the body length was 21 inches. Abnormal stools were noted first while the child was still in the newborn nursery. These were said to be copious, mushy and green. Various milk formulae did not alter the frequency or consistence of the stools. From the age of three months the feces were always large, frothy and soapy. At the age of three months the baby weighed eight pounds and was 22 inches in length. At six months he weighed 12 pounds and was 25 inches in length. At eight months the weight was 13½ pounds.

There was no retardation in development and the child walked unaided at 16 months and talked quite well at 24 months.

At the age of 18 months the first respiratory infection took place, accompanied by fever and a cough. This was of short duration but at 24 months of age a more severe respiratory infection occurred which became chronic, leaving the child with a persistent non-productive cough.

The "peculiar stools" were constant and averaged about 15 per day. Because of them, the patient had been receiving a so-called "celiac diet" consisting of skimmed milk, cottage cheese, jello, bananas with added vitamins A, B, C, D and G. At two and one-half years the boy weighed 27 pounds.

Present Illness: Three months prior to admission the patient developed an acute infection characterized by fever, nasal discharge and exacerbation of his chronic cough. The course of this illness was characterized by daily spikes in temperature to 104.5° F. Physical examination revealed extensive signs of pulmonary consolidation over the entire right chest. This was confirmed by roentgenograms. Resolution of the process was very slow and after two months there had been no observable change in physical or roentgen findings. A diagnosis of "virus pneumonia with delayed resolution" had been made prior to hospital admission. During this illness the cough was productive of sputum most of which was swallowed.

Review of the history at this time revealed no known exposure to tuberculosis.

Physical Examination: Temperature 99.5°F; pulse 130; respiration 30. The patient was an irritable, but alert three and one-half year old boy appearing chronically ill. The skin was pale, waxy and sallow and there was fading miliaria over the trunk. The lymph nodes were not remarkable. The abdomen was protuberant, measured 18¾ inches in circumference and was tympanitic. No masses were felt and there were no points of tenderness. The chest measured 19¾ inches in circumference. There was impairment to percussion over the entire right chest posteriorly. Scattered rales were heard over this area and the breath sounds were bronchovesicular. The left chest was entirely clear to auscultation and percussion. The heart was normal. The head measured 19¾ inches in circumference; the fontanel was closed. The eyelashes were remarkably long and curly. The tonsils were large but did not appear infected. The extremities were very thin and the buttocks were flattened. Neurologic examination disclosed only normal findings.

Laboratory Data: 3-28-43: Hemoglobin 8.8 grams, Red blood cells 2,710,000, White blood cells 13,900, Neutrophiles 68 per cent, Lymphocytes 25 per cent, Monocytes 6 per cent, Eosinophiles 1 per cent. 4-3-43: Hemoglobin 12.8 grams, Red blood cells 4,520,000, White blood cells 14,050, Neutrophiles 78 per cent; Lymphocytes 15 per cent, Monocytes 6 per cent. Urinalysis was negative. X-ray examination of the chest showed a patchy infiltrate throughout the entire right lung, more marked in the upper lobe area. There was a small amount of fluid on the right side. The left side appeared clear. No fat studies were done on specimens of feces and no examination of duodenal contents for enzymes was made.

Course: Three small blood transfusions were given to correct the anemia. The daily temperature ranged between 99.6° and spikes to 103.4° F in the afternoon. The respiratory rate was between 30 and 40. The child's appetite was voracious and on a fat free diet he ate huge quantities of jello, cottage cheese and fruit sherberts. His cough was persistent. He was allowed to go home on his 7th hospital day, unimproved except for the anemia. The clinical diagnoses were: Congenital cystic fibrosis of the pancreas; unresolved broncho-pneumonia; secondary anemia and malnutrition.

On April 23, 1943, 19 days later, the patient was readmitted to the hospital just after his mother had been found to have active pulmonary tuberculosis. During the interim the child's health had failed markedly and on admission there was noticeable respiratory distress. The findings on examination of the chest and abdomen were essentially as before. Purified protein derivative tuberculin test, first strength, was negative; second strength was positive. A search for acid-fast bacilli in the sputum failed to reveal any organisms. The daily temperature continued to range between 98° and 104.4° F. The patient became dyspneic and very weak; he was placed in an oxygen tent where he expired on the 7th hospital day of the second admission. **The final**

*This is the eighteenth in a series of "Case Records Presenting Clinical Problems" selected by Richard S. Austin, M.D., professor of pathology, University of Cincinnati College of Medicine.

The authors represent respectively the Medical and Pathological Services of The Children's Hospital, affiliated with the Cincinnati General Hospital.

clinical diagnoses were: Congenital cystic fibrosis of the pancreas; pulmonary tuberculosis.

NECROPSY (C-43-21)

Gross Examination: The upper lobe of the right lung was bound to the parietal pleura by dense fibrous adhesions, was almost totally consolidated and was largely replaced by numerous large yellow coalescing areas of caseous necrosis. A scanty amount of practically non-air-containing gray tissue remained between these areas of necrosis. Throughout the middle and lower lobes of this lung and especially prominent in the base of the lower lobe, there were scattered small thin-walled cavities filled with creamy-white purulent exudate. The tissue of the entire left lung was sub-crepitant and congested and a somewhat firm area of consolidation, speckled with small yellow caseous tubercles, was located in the apex of the lower lobe. The bronchial tree was lined by a reddened mucosa and its branches, including the smaller ones, were dilated and filled with purulent exudate. The bronchial lymph nodes on the right side were enlarged and were spotted with small or large gray and soft yellow tubercles. Several mediastinal lymph nodes also were enlarged and consisted of a central white cheesy area of necrosis, surrounded by a rim of grayish-white fibrous tissue.

The pancreas was in normal position. It was very small and was markedly decreased in diameter although only slightly decreased in length. The tissue was somewhat gritty and was arranged in small white lobules widely separated by gray fibrous tissue. The tail of the pancreas was slightly larger than the body and was speckled with numerous tiny cysts measuring 1 millimeter or less in diameter. No cysts were seen in the body or head and the entrance of the pancreatic duct into the duodenum was not found.

The large bowel was dilated throughout its entire length; the dilatation was especially marked in the sigmoid colon and rectum where there was obvious thickening of the musculature. The colonic mucosa was flattened, smooth and without ulceration and the feces in the terminal colon were well formed and normal in color. The alimentary tract proximal to the ileo-cecal valve appeared normal.

There was slight enlargement of the liver, the substance of which was slightly swollen, tan and mottled with small and large areas of yellow. There were no abnormalities of the extrahepatic bile passages. No noteworthy patholigical changes were found in the other abdominal viscera or in the heart. The cranial cavity was not explored.

Microscopic Examination: There was widespread caseous pneumonia throughout the upper lobe of the right lung and to a lesser extent in the apex of the lower lobe of the left lung. In addition numerous single and conglomerate caseous tubercles were present in the framework, some of these tubercles presenting little inflammatory response while others were associated with a moderate degree of surrounding fibroblastic, lymphocytic, epitheloid cell and giant cell response. A few areas of non-specific organizing pneumonia were also present in close proximity to the tuberculous process but were related to small areas of acute and resolving lobular pneumonia. There was dilatation of the bronchi and bronchioles with ulceration of the mucosa, lamina propria and muscularis and active chronic inflammation of the wall. Several of these bronchi terminated in small abscesses in the pulmonary tissue. Many of the bronchi were filled with pus while a few presented tuberculous ulceration of the mucosa and underlying tissue. An occasional bronchiole was lined by squamous epithelium without keratinization. No metaplasia of the mucosa of the larger bronchi or of the mucosa of the bronchial and tracheal glands was noted. Sections of other lobes of the lungs presented a picture of active chronic ulcerative bronchitis with bronchial abscesses, acute lobular pneumonia with abscess formation and resolving pneumonia. Numerous small areas of active tubreculous infection as represented by caseous and fibrocaseous tubercles peppered the bronchial, mediastinal and mesenteric lymph nodes. Acid-fast bacilli were demonstrated in lesions in sections stained with carbol-fuchsin.

In the head of the pancreas there were numerous widely dilated, small and large pancreatic ducts filled with a granular pink precipitated secretion. The lobules consisted of groups of glands some of which were atrophied while others were markedly distended with inspissated secretions. The latter glands were lined by flattened epithelium. There was marked fibrosis, moderate lymphocytic infiltration and moderate invasion by fat of the interstitial tissue which widely separated the lobules and the glands of the lobules. The main pancreatic duct as it coursed through the body of the pancreas was widely dilated. The lobules in this portion were replaced by fibrous tissue, infiltrated by lymphocytes, and only a few atrophic and a few dilated acini remained. In the tail of the pancreas the acini were extremely scanty and the few which remained were very markedly dilated with flattened epithelial linings. Fibrosis was marked. The islands of Langerhans throughout the entire organ were intact and well preserved.

There was fatty infiltration of the liver, this change having no predilection for the cells of any portion of the lobule. No striking pathological changes were noted in the remaining viscera.

The final pathological diagnoses were: Advanced cystic fibrosis of the pancreas; fibrocaseous pulmonary tuberculosis and tuberculous pneumonia; fibro-caseous tuberculous bronchial, mediastinal and mesenteric lymphadenitis; tuberculous bronchitis; acute and chronic bronchiectasis; acute and organizing lobular pneumonia; dilatation of the colon with hypertrophy of the musculature; marked fatty infiltration of the liver.

COMMENT

The etiology of cystic fibrosis of the pancreas is obscure but it is thought that in most, if not in all cases, the condition is present at birth and that the pancreatic lesions can be interpreted as a result of congenital obstruction of the pancreatic ducts. With obstruction of these ducts the exocrine secretions of the pancreas fail to reach the duodenum, with resultant failure of absorption of certain foods, particularly fats and protein, and failure of absorption of fat soluble vitamin A. Acute and chronic respiratory infections follow and these are explained by the theory that metaplasia of the epithelium of the bronchi and bronchial glands occurs as a result of vitamin A deficiency and that these changes pave the way for infection.

Farber, however, accepts the role of congenital obstruction of the pancreatic ducts as the factor responsible for the pancreatic lesion in cases of meconium ileus in the neo-natal period, but suggests that in most cases of cystic fibrosis of the pancreas the obstructive process begins in the pancreatic acini and is secondary to the production of an abnormal pancreatic secretion which becomes inspissated. The findings of inspissated material, in the mucus glands of the trachea, bronchi, esophagus, duodenum and salivary glands suggested to Farber that the disease is a systemic one and thus may be manifest by a variety of clinical appearances depending on when the obstruction occurs and which organs are involved.

Clinically the diagnosis of cystic fibrosis of the pancreas is difficult and particularly so in early infancy. Death may occur during the first two weeks of life from intestinal obstruction caused by inspissated meconium or by an associated intestinal atresia. Later, death most frequently is the result of chronic pneumonitis and chronic bronchiectasis. The "celiac syndrome" may be the most prominent feature of the disease. With the recognition of this syndrome, difficulties of diagnosis may be encountered since much similarity exists in the clinical pictures of celiac disease and cystic fibrosis of the pancreas. However, as pointed out by Andersen, great assistance in identifying cases of cystic fibrosis of the pancreas can be obtained from an analysis of the history for in this disease there is a familial tendency, an early onset of symptoms, usually before the fourth month of life, an early appearance of large foul stools, an absence of diarrhea, poor weight gain in spite of a good appetite, and a susceptibility to repeated respiratory infections which later become chronic. The laboratory affords the most reliable means of establishing the diagnosis by means of an assay of the duodenal juice for pancreatic enzymes.

CLINICAL PICTURE

The clinical picture presented by this child from the age of three months was that of the celiac syndrome and was very strongly suggestive of cystic fibrosis of the pancreas. However, examination was not made to determine the absence of pancreatic enzymes in the duodenal juice nor was there any chemical analysis of the feces. Xerophthalmia which is occasionally associated with the disease was absent.

Pathologically the pancreatic lesion, including marked interstitial fibrosis, dilatation of many of the exocrine glands with inspissated secretion, destruction of many of the remaining glands, dilatation of the pancreatic ducts and normal appearing islands of Langerhans, is quite characteristic of the disease. Although the failure grossly to demonstrate the pancreatic duct in the head of the pancreas does not establish the absence or occlusion of this duct, the microscopic picture in this organ is similar to that seen in connection with obstructive lesions. The chronic respiratory infection was of two types, tuberculous and pyogenic. Tuberculosis is not a common complication of the disease. Respiratory infection due to the staphylococcus aureus, however, has frequently been reported. Clinically the child suffered a respiratory infection at eighteen months of age and again at the age of two years, the latter infection becoming chronic. On the basis of the microscopic appearance it is impossible to estimate the age of the older tuberculous lesions, and the possibility remains that these lesions were established at the earlier age. A factor possibly favoring a later onset of the tuberculous process is the fact that the diagnosis of active pulmonary tuberculosis in the mother was not established until the child was over 3½ years of age but this again does not preclude the presence of active tuberculous infection of the mother during the previous two years. It is therefore rather difficult to determine which infection ante-dated the other, although the probable order of events is super-imposition of the tuberculous infection on an original pyogenic infection.

TREATMENT

The treatment of cases of this kind has been rather unsatisfactory up to the present. The clinical picture is a result of failure to absorb various foods although there are some foods which can be absorbed more completely than others as these patients do gain some weight. The treatment as advocated by Andersen is a celiac diet with feedings of 20 per cent to 40 per cent more than the estimated caloric requirements and modified by the use of a high protein diet mixed with pancreatin. All vitamins, particularly vitamins A and D, should also be administered generously. However, even with the best efforts there remains a deficiency in the caloric intake, fat and vitamin A.

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The healthy know not their health, but only the sick.—Thomas Carlyle.

Happy the physician who is called in at the end of the illness.—Rabelais.

Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

TUBERCULOSIS IN SCHOOLS

THE Legislative Assembly of the Province of Quebec on May 17, 1941, unanimously passed an act stating that no person could teach in a public, private or independent school unless he produces every year a physician's certificate stating that he "suffers from no infirmity or disease which renders him unfit for teaching" and "a certificate from a phthisiologist attesting that a clinical and radiological pulmonary examination shows that such person is free from tuberculous disease". Such examinations must be made within two months following the engagement. Should any teacher prove to be tuberculous the contract to teach is immediately rescinded.

If Quebec glories in being the first province in Canada to pass such a law it must be admitted that it is the one to need it most—having the highest death rate from tuberculosis among the Canadian provinces. Three factors led to the passage of the law. First, a three-year educational campaign on tuberculosis which reached most of the population; second, a law passed by the city of Quebec requiring all teachers of the School Commission to undergo examinations for tuberculosis, including a chest X-ray. Out of 523 teachers examined 16 were withdrawn from teaching because of active chronic tuberculosis. The third factor was a personal experience published in an educational review which demontrated mass contamination of pupils by a tuberculous teacher.

The legislation was introduced by the Council of Education of which all the bishops of the Province are members, so the doors of the teaching religious congregations were thrown open.

Difficulties arose in the enforcement of this new law as was to be expected, but these were overcome as the organization proceeded. In rural districts the expense was borne by the Board of Health, in Montreal the Catholic and Protestant school commissions paid for the X-Ray films.

The results of the examination of 16,524 teachers in the Province of Quebec, with the exception of the city of Montreal, are shown in Table I.

It is apparent that tuberculosis was twice as prevalent among religious teachers as it was among the lay teachers, even though most of the religious congregations have required, for the past few years, an X-ray examination of the chest from all applicants for admission to their groups.

TABLE I

Examination of school teachers for tuberculosis
All the Province of Quebec except the City of Montreal

Type of teacher	Number of teachers examined	Number of teachers rejected for tuberculosis[1]	Per cent of total examined rejected for tuberculosis
Total	16,524	212	1.3
Females	13,553	178	1.3
Religious	6,152	115	1.9
Lay	7,401	63	0.9
Males	2,971	34	1.1
Religious	2,155	27	1.3
Lay	816	7	0.9

[1]Includes some persons with non-active disease and some under observation.

TABLE II

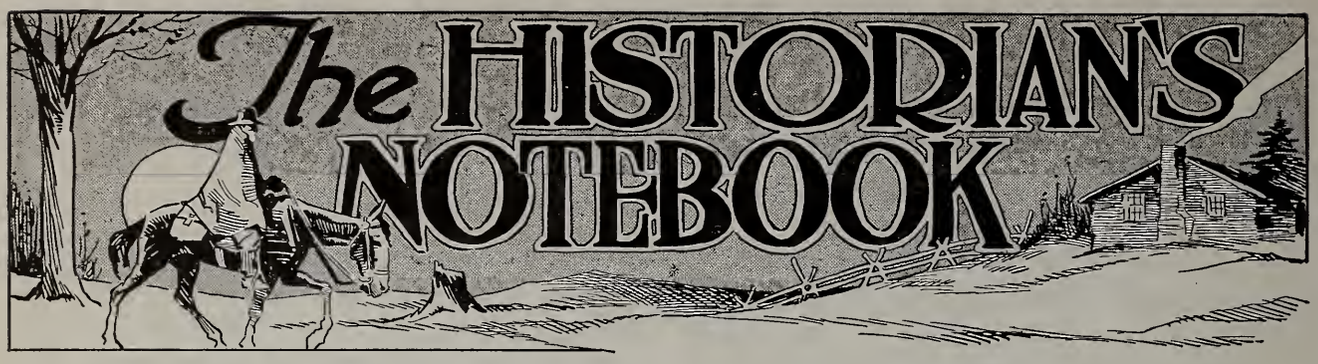
Examination of school teachers for tuberculosis
City of Montreal—Catholic School Commission

Type of teacher	Number of teachers examined	Number of teachers rejected for tuberculosis[1]	Per cent of total examined rejected for tuberculosis
Total	4,695	15	0.32
Females	2,785	9	0.32
Religious	1,879	3	0.16
Lay	906	6	0.66
Males	1,910	6	0.31
Religious	1,148	..	...
Lay	762	6	0.52

[1]Includes only active cases.

In the city of Montreal, the results of examination for tuberculosis do not show the same trend. According to Dr. Laberge, the report was not complete for the religious teachers. The data from the Catholic School Commission are summarized in Table II.

The Protestant School Commission reported 1,533 teachers X-rayed, only one of whom was rejected.—Detection of Tuberculosis in School Teachers in the Province of Quebec, L. Laberge, M.D., Canadian Journal of Public Health, March, 1943.



Kept by David A. Tucker, Jr., Cincinnati, Ohio

Milksickness in the Western Country Together With an Account of the Death of Lincoln's Mother

PHILIP D. JORDAN, Ph.D.

INSIDE the cabin there was sickness. For almost a week the woman had ailed until she no longer could struggle up to glimpse the autumn foliage which was touching Pigeon Creek with color. As Nancy Hanks Lincoln saw the rude log house, unfinished for more than a year, she may have felt that Indiana in 1818 was not quite the promised land to which she had so readily agreed to go. Her bedstead, a crude affair of poles stuck between the logs in a corner of the cabin, sagged when she shifted so that she might see the heavy, hewn log table, the three-legged stools, the iron pot and spider, and the tin and pewter dishes. In the loft, the October wind, sifting through unchinked logs, shuffled the leaves upon which her son, Abe, slept. Then the weakness and dizziness came again.

The settlers of Pigeon Creek knew what that meant. Thomas Lincoln had coffined Betsy and Thomas Sparrow and only about a week earlier had helped bury Peter Brooner's wife whose home was half a mile away. The mysterious milksickness, known in North Carolina since colonial days, was following the frontier, stalking the pioneer as stealthily as the hunter tracked the deer. It attacked milch cows as well as men and was called by many names. Some knew it as the "trembles", the "staggers", the "tires" or "slows", and the "bloody murrain". Others spoke of it as "swamp sickness", "puking fever", or "river sickness". Most frontiersmen, however, simply referred to it as the "milk sick". And they were afraid of it, because, even though they had seen a few milksick patients recover, they had watched many more die.

The Author

● **Dr. Jordan, Oxford, Ohio, is associate professor of history at Miami University, Oxford, Ohio.**

What caused the disease no man knew. No remedies prevailed against it. Even the pioneer physician had nothing in his saddlebags that could halt the persistent course of the disease. Neither the lancet nor the leech did anything but exhaust the patient. Heroic doses of lobelia and of herb infusions were only professional gestures. Within a period ranging from two to nine days most milksick victims lay decently on a cooling board. Yet, if no one understood the cause of the disease, many were acquainted with its characteristic symptoms. Nancy Hanks Lincoln must have manifested them all.

No doubt she was wearied from her nursing care of the Sparrows and of Mrs. Brooner, so that she paid little attention to the lassitude which forced her to rest as she went about her home chores. Perhaps she gave little heed to increasing spells of dizziness and attributed her loss of appetite to over-exertion and fatigue. But she must have realized, when the nausea and persistent vomiting came on, that the milksickness had struck. When Thomas Lincoln saw her with pain in the region of the stomach and heard her, in her great thirst, ask for water, he too must have guessed the truth. In all likelihood, he was prepared for the death of his thirty-five-year-old wife before she had been ill many hours.

Nancy Lincoln, exhausted by persistent vomiting, probably was put to bed within two or three days after the onset of the disease where she lay restless, her usually active mind dulled. At times neighbors, such as William Wood, came and sat with her. Perhaps they ministered without her knowledge, for semi-consciousness frequently closes in upon the milksick patient. Obstinate constipation, a scant urine of pale color, and continued pains in the abdomen must have been present. She probably complained of pain in the calves of her legs and of stiffness. Her hiccoughs were of the same type as that of other victims of the murrain. Had her husband asked to see her tongue, he would have observed it to be red and unusually large with a slight tremor and parched into fissures of white. Her eyes were rolled upward with the pupils reacting sluggishly and the ocular conjunctiva reddened. A yellow, gummy discharge was present at each canthus. The abdomen, as the disease progressed, became scaphoid and later tympanites, or distention of the abdominal walls, appeared. No peristalsis was present. The patient now was entering the final stages.

If she followed the typical pattern, she lay on her back with her head turned to the side and her legs were drawn up with the knees spread apart. A decided odor of acetone was on the breath and in the urine. Her respiration was becoming irregular and of the Cheyne-Stokes character, a succession of respirations becoming progressively shorter and more shallow, then an intermission of varying duration, followed by progressive increase in depth and length. Such respiration always signifies approaching death. The skin becomes cold and clammy. Had her pulse been taken it probably would have been irregular and varying from 70 to 120. The temperature of all milksick individuals is subnormal, and Mrs. Lincoln's probably never exceeded 99 degrees. Blood pressure possibly ranged from 67 to 95.

Before prostration and final coma prevented it, Nancy Lincoln called her two children, Sarah and Abraham, to her and "told them to be good to their father, to each other, and to reverence God". Not long after that she must have slipped into complete coma and died quietly on the seventh day of her illness. She passed away in October—perhaps the fifth—and was buried in a box made from rough lumber and joined by wooden pegs. Not until sometime later did a visiting Baptist preacher visit Pigeon Creek and preach a funeral sermon over the graves of Nancy Lincoln, her foster parents, and Mrs. Brooner.

Had autopsy been an established procedure in the backwoods during the early decades of the nineteenth century, a pathologist's post-mortem knife would have exposed the terrific organic changes produced in Mrs. Lincoln by her seven-day sickness. The mucosa of the stomach were highly inflamed, indicating an intense gastritis; both intestines were distended with gas, the reason for her tympanites or "drum belly"; the mesenteric lymph nodes were enlarged and possibly inflamed; and her liver was much enlarged, yellowish-red in appearance, and hard as if stuffed with fat. Although pancreas and spleen were normal, the kidneys probably were enlarged, perhaps as much as one-third.

Further examination would have revealed fatty changes in the ventricles and perhaps edema of the heart. Many small areas of atelectasis were present in the lungs which indicated a pulmonary collapse occasioned not by a disease in the lungs themselves, but by the prolonged weakness so characteristic of milksickness. The kidneys revealed intense diffuse parenchymatous, an inflammation of the parenchyma, and well-defined glomerulitis, or inflammation of the Malpighian bodies of the organ. Microscopic analysis would have discovered that the nuclei of liver cells were greatly diminished in number. No pathological changes would have taken place in the brain. Findings such as these would confirm a diagnosis of milksickness.

No doubt the Lincolns and other settlers in the vicinity of Pigeon Creek wondered and talked about the cause of this puking fever which, quiet as the forest shadows, was making the back-of-beyond a place of death. Perhaps they advanced explanations and theories as other men were to do for more than a hundred years before they finally solved the mystery of an endemic, frontier disease which for decades weakened the pioneer, took its toll of life, and baffled the medical profession. It made dreadful ravages among early settlers, often causing them to break up communities and seek healthier locations. Indeed, if John Hanks can be believed, it may have been among the reasons which prompted Thomas Lincoln and his new wife, Sarah, to leave Indiana for the Illinois country. Hanks wrote: "The reson is this we war perplext By a Disese cald Milk Sick my Self Being the oldest I was determined to Leve and Hunt a Country where the milk was not . . ."

It was not going to be easy, however, to find a safe location in the Old Northwest. Thomas Ashe, as early as 1806, appears to have identified the milksickness among the settlers on the Ohio River, and three years later, Thomas Barbee, a Virginia physician traveling through Ohio, discovered the disease in the Mad River district. In 1810 and again in 1815, Daniel Drake, most competent physician in the western country, published the first definite reports on the "sick-stomach". "It has been," he wrote, "ascribed to some

noxious impregnation of the water; to the use, by the animals whose milk and flesh are eaten, of some deleterious plant and to marsh exhalation—the last of which is the most plausible." Drake, intrigued by the unique nature of this disease which was causing so much consternation among emigrants and settlers, began to study milksickness with a determination to discover its cause, pathology, and treatment.

Articles, for the next 20 years, appeared in the distinguished medical journals of the western country. Editors of periodicals such as the *Translyvania Journal of Medicine and Science*, the *Western Journal of Medicine and Surgery*, and the *Nashville Journal of Medicine and Surgery* were only too glad to open their columns to information which might assist the pioneer doctor in treating the scores of frontiersmen who were succumbing to the murrain.

Travellers, hunters, and settlers, penetrating the forest wilderness, all too frequently came upon evidence of milk fever in backwoods communities, on river boats, and in new-turned graves. Faux talked with a farmer near old Vincennes who spoke bitterly of the trembles; Long found it along the Missouri River; and Flagg spoke of it as prevailing in certain isolated districts of Illinois where, he said, whole villages were depopulated, so that it created a "perfect panic" among the settlers. Physicians in Kentucky and Tennessee described the disease in *The Western Lancet*, and the legislature of Kentucky appointed a committee in 1827 to investigate the milksickness problem. In Indiana, the state medical society attempted the same work. J. M. Peck, author of one of the most enthusiastic guides to the West, despaired when he wrote of the milk fever and admitted sadly that "physicians and others who have tried to determine its cause have had no success."

During succeeding decades both the volume of literature and the confusion increased. Reuben G. Thwaites, for example, wrote in 1906 that milksickness was "no longer so diagnosed by medical authorities", although even while he was penning those words, new outbreaks of the disease were occurring in Illinois and New Mexico, and physicians and laboratory researchers were still talking of milksickness. Osler's *Principles and Practice of Medicine*, the most widely consulted text of the day, still retained the old name, milksickness.

To illustrate further the degree of misinformation concerning milksickness which even today creeps into literature, one has only to read the passages describing the disease in Bruce Lancaster's novel of the Lincoln country, *For Us, the Living*. And within the past six months, Mr. Lancaster, in the pages of *The Abraham Lincoln Quarterly*, has asked the same questions which the Lincolns of Pigeon Creek and scores of other settlers, in their bewilderment, put to one another. "Has this strange visitation ever been explained?" wrote Lancaster. "Has it ever cropped out in other parts of the country?"

The answer to both queries is in the affirmative. The cause of milksickness was almost found by a score of pioneer observers and scientists. Drake, it will be remembered, mentioned that some "deleterious plant" might be the active agent; Faux related that poisonous herbs caused trembles among cattle; Long spoke of the effect of "noxious plants", and Flagg said that Illinois settlers ascribed the disease "to the milk or to the flesh of cows feeding upon certain unknown poisonous plants". The medical literature of the thirties, forties, and fifties, in general mentioned the possibility of poisonous milk caused by cows eating injurious vegetation.

A variety of other theories also were advanced. Poisonous dew and volatile minerals that evaporated from the earth at night, condensing on the herbage, there to await ingestion by grazing herds; miasmata, the early conception of a germ theory; micro-organisms; various poisonous minerals, such as compounds of arsenic, copper, lead, and cobalt, as well as poisonous springs—all these were advanced as explanations of the origin of the malady. In 1879, for example, the National Board of Health advanced the idea that a spirillum in the blood, akin to that observed in relapsing fever, was the activating agent. Two members of the bacteriological laboratory of the University of Chicago, in 1909, cautiously suggested that a bacillus, which they named *B. lactimorbi*, possibly was the cause. About the same time, it was stated positively that milksickness was due to aluminum phosphate.

All of these theories, although they seemed based upon conclusive experimental evidence, were incorrect. The solution was found only when attention once more turned back to the poisonous-plant theory as advanced by the earliest commentators. Although many plants were suspected—poison-ivy, waterhemlock, Virginia creeper, coralberry, spurge, mushrooms, marsh-marigold—the hunt finally centered upon the white snakeroot which W. J. Barbee, of Marshall, Illinois, and D. D. Owen had identified in 1840 as *Eupatorium ageratoides*, although it now is called *Eupatorium urticaefolium*. Barbee and Owen, however, were not among the first to distrust the white snakeroot. An Ohio farmer in 1837 definitely advanced the view that the plant when eaten by cattle whose milk was drunk by settlers induced the disease. Vermilya's thesis was published in the annual report of the Ohio State Board of Agriculture in 1858 and was reprinted in the report for 1873 when Buckeye farmers were cautioned against the root and told

that were the plant well known a few hours would be sufficient to eradicate it entirely from any farm.

The plant itself was not difficult to recognize. Its head ranged from three to many flowers. The flowers were perfect, involcre, cylindrical or bell-shaped with a flat receptacle. The corolla was five toothed, and the achemia five angled. A perennial herb, it often was sprinkled with bitter resinous dots, with generally corymboic heads of white, bluish or purple blossoms which appear near the close of summer.

Even though the *Eupatorium urticaefolium* was well described and substantial evidence offered to prove its connection with trembles in cattle and milksickness in man long before the turn of the nineteenth century, the Bureau of Plant Industry of the United States Department of Agriculture maintained in 1908 that "it certainly cannot be said that it has been proved that milksickness is due to any constituent of *Eupatorium ageratoides*."

But intense investigation now began, and in 1917 it was demonstrated conclusively that the white snakeroot was toxic, although the active agent had not been isolated. Ten years later, as the result of a long chain of biochemical and pharmacological experimentation, the actual culprit was apprehended, not only in the white snakeroot, but also in jimmyweed or rayless goldenrod (*Aploppapus heterophyllus*), and in a plant having no well-known common name, but called by botanists *Aulopappus fruiticosus*. Jimmywed grows from southern Colorado to western Texas, New Mexico, and Arizona, and extends southward into Mexico, and the *A. fruticosus* is common to Arizona, Texas, and Mexico. The white snakeroot, of course, was common, during pioneer days, to Tennesee, Kentucky, the states of the Old Northwest, and today grows widely throughout the eastern part of the United States and as far west as Minnesota, Nebraska, Oklahoma, and Texas.

These plants, extending over a rather broad area, contain a poisonous substance known as tremetol which is the cause of milksickness. Nancy Hanks Lincoln in reality died from tremetol poisoning as the result of drinking milk from a cow that had fed upon the white snakeroot. Tremetol is a viscous levorotatory oil with a pleasant aromatic odor. Its chemical composition is $C_{16}H_{22}O_3$. It is classed chemically with the higher alcohols, is insoluble in water, acids, and alkalies and is soluble in the common organic solvents, alcohol, chloroform, and ether. Taken into the body and digested, tremetol will produce all the symptoms which Mrs. Lincoln manifested during her illness. The pronounced odor of acetone which was on her breath and present in her urine (even though no frontiersmen knew of the acetonurometer) was a ketosis, a condition of faulty metabolism which, in reality, was a secondary manifestation of chronic tremetol poisoning.

Even though the cause of milksickness now has been determined, treatment of the patient is precarious, relapses are common, and mortality is high. Today medical care consists of supportive measures, combating the ketosis, and relieving the constipation. The use of enemas of glucose and sodium bicarbonate is recognized procedure. Rest is absolutely essential, and a milk diet is indicated provided the milk is not infected.

Within certain limitations Mrs. Lincoln probably could have received about as effective medical aid from her family and neighbors as any modern physician could give. Most frontier housewives kept a supply of saleratus for use in baking. This could well have been used as a substitute for the refined sodium bicarbonate. The woods were adequately supplied with honey trees. A clyster composed of warm water, honey, and saleratus would have furnished a substitute for an enema of glucose and sodium bicarbonate. Enemata apparatus was not unknown to the pioneer who, if he could not afford a cheap French enema pipe, could easily manufacture one—as many did—at home. A hog's bladder and a hollow reed served time and again as crude, but effective, enema apparatus.

Whiskey usually was available on the frontier, and if whiskey and honey had been given Mrs. Lincoln during the early days of her illness she possibly would have reacted promptly and successfully. Administration of whiskey causes an ester of tremetol to be formed which is less toxic and, as the result of physiological changes, helps to liberate the poison and to combat the ketosis. The saleratus would have relieved the acidosis, and the enema would have combatted the constipation. Yet with practically all the agents for treatment at hand, Mrs. Lincoln died, as did so many settlers, a victim of medical ignorance and of one of the great scourges of the western frontier.

Hypersensitivity and Rheumatic Carditis

Arnold R. Rich and John E. Gregory in the October, 1943, issue of the *Bulletin of the Johns Hopkins Hospital* present some interesting experimental observations which suggest that the cardiac lesions of rheumatic fever may be the results of hypersensitive reactions of the anaphylactic type. Rabbis were subjected to experimental serum sickness and in some cases developed cardiac lesions that, in their basic characteristics, resemble closely those of rheumatic carditis.—Conn. State Medical Jr., Vol. III, No. 8, Aug., 1944.

Party Platforms and Statement by G.O.P. Governors At St. Louis Reflect Views on Medical, Health Issues

IN any election year, the members of the medical profession, as physicians and voters, ask, and have a right to ask: What is the attitude of the parties and of the candidates on matters involving public health activities and the practice of medicine?

This question becomes even more significant this year because of the furore which has been created by the Wagner-Murray-Dingell Bill and the activities of the Children's Bureau and because of the large amount of publicity which has been given to other proposals to expand health and medical activities of the Federal Government.

CANDIDATES TO BE INTERVIEWED

Between now and the General Election on November 7, candidates for various offices will be interviewed by members of the state and local legislative committees of the Ohio State Medical Association. Information obtained will be disseminated to Ohio physicians.

The best information available at this time as to how the Democratic and Republican parties stand on general policies and principles bearing on health and medical questions will be found in the platforms adopted by the two parties at their recent conventions at Chicago and at the recent meeting of Republican governors at St. Louis.

Physicians should read the following excerpts from these documents carefully as only the informed voter is prepared to vote intelligently.

REPUBLICAN PLATFORM

Under the heading "Security", this is what the Republican platform has to say about Federal participation in health and allied fields:

"We pledge our support of the following:

"1. Extension of the existing old age insurance and unemployment insurance system to all employes not already covered.

"2. The return of the public employment office system to the states at the earliest possible time, financed as before Pearl Harbor.

"3. A careful study of Federal-state programs for maternal and child health, dependent children, and assistance to the blind, with a view to strengthening these programs.

"4. The continuation of these and other programs relating to health, and the stimulation by Federal aid in state plans to make medical and hospital service available to those in need without disturbing doctor-patient relationships or socializing medicine.

"5. The stimulation of state and local plans to provide decent low cost housing properly financed by the Federal Housing Administration, or otherwise, when such housing cannot be supplied or financed by private sources."

DEMOCRATIC PLATFORM

Here are the planks in the Democratic platform that refer directly or indirectly to a health program:

"Beginning March, 1933, the Democratic Administration . . . provided social security, including old age pensions, unemployment insurance, security for crippled and dependent children and the blind. . . . We pledge the continuance and improvement of these programs.

* * *

"We offer these postwar programs:

"A continuation of our policy of full benefits for ex-service men and women with special consideration for the disabled. . . .

"The enactment of such additional humanitarian, labor, social and farm legislation as time and experience may require, including the amendment or repeal of any law enacted in recent years which has failed to accomplish its purpose.

* * *

"We reassert our faith in competitive private enterprise free from controls by monopolies, cartels, or any arbitrary private or public authority."

G.O.P. GOVERNORS' STATEMENT

In the statement of policy adopted by the Republican governors and submitted to Governor Dewey of New York, the Republican presidential nominee, there appeared the following chapter, entitled "Social Welfare, Education and Public Health":

"The administration of public welfare belongs primarily to the states and the localities because welfare problems are so intimately a problem of the community. Financial responsibility, on the other hand, may need to be spread more widely because welfare burdens often are unduly severe where a state or locality has unusual burdens or is itself in financial difficulty.

"The period of postwar demobilization will mean that many families and individuals who have moved to industrial areas to aid in the war effort by their labors will find themselves stranded in communities which are hard-pressed by the termination of war industry, or will be returning home or seeking employment in other areas. There will obviously be problems of social and economic adjustment for many of these persons. This is an interstate problem created

by the war effort—the solution of which calls for Federal leadership and help.

"In thinking of the mutual welfare responsibilities of Federal and state governments, we need to bear in mind the increasing significance of the social insurances. Unemployment compensation will in the days ahead provide assistance during limited periods of unemployment. Increasingly over the years, especially if its coverage is extended as it should be in old age and survivors' insurance will gradually assume a greater burden of the care for the aged, widows with dependent children and the disabled.

REORGANIZATION SUGGESTED

"Reorganization of the Federal administration of welfare services looking toward consolidation of agencies and simplification of procedure is called for to avoid the present warfare among Federal agencies and the resulting chaos in administration throughout the country.

"Our efforts in the states to develop co-ordinated social services to our people are frequently thwarted by the competitive demands of Federal bureaus operating grant-in-aid programs in these related fields. The will to serve the needs of people rather than the perpetuation of a bureau must permeate national participation in the public social services. Not only should the Federal welfare bureaus be brought together, but in

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OBSTETRICS—Two Weeks Intensive Course starts October 16.

ANESTHESIA—Two Weeks Course Regional, Intravenous & Caudal Anesthesia.

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addition, their administration should be tied in closely with related programs in the fields of public health, education and vocational rehabilitation.

"A republic more than any other form of government depends upon trained and intelligent citizens. The founders of our republic knew that the basic safeguard of our liberties and constitutional government is the universal education of our people. The opportunity for an education is, therefore, the birthright of every American, irrespective of race, economic status, or place of residence.

DECENTRALIZED CONTROL URGED

"An education that will guarantee every child a decent start in life and that will prepare him for the unprecedented responsibilities that will follow this war, is the joint obligation of the local community, the state and the nation. In the fulfillment of this obligation the control and administration of our free public schools should remain with the states and local communities.

"Great efforts have been made by our local communities, the states and the Federal Government to protect and improve the public health. The recent medical examination by our draft boards and military authorities of men and women applying for admission to the military and auxiliary forces or subject to the draft, however, have revealed deficiencies in the health of our nation. In the face of these findings, as soon as the war is over, measures should be taken for a more effective improvement of the people's health.

NO POLITICAL CONTROL OF MEDICINE

"In achieving these objectives, the following principles should be observed:

"1. The states and the local communities should improve their existing hospitalization, clinical treatment, visiting nursing and other public health programs, as far as their resources permit.

"2. There should be no political control of the profession of medicine.

"3. The existing scattered Federal agencies concerned with various aspects of the public health, should be more closely integrated."

The Kill-the-Sales-Tax League failed to qualify its petitions seeking submission to the voters in November of a constitutional amendment outlawing the state sales tax. Proponents claimed to have more than the required 179,654 signatures distributed throughout 44 counties, but said they were unable to have them "properly notarized" before the deadline, August 9.

Demorol Supply Must Be Reported To Officials

By a recent act of the U.S. Congress, isonipecaine, commonly known as "demorol", has been brought under the provisions of the Federal Narcotic Laws. Any retailer or practitioner procuring or prescribing demorol must be registered under the Harrison Narcotic Act and must submit to the Collector of Internal Revenue, on or before September 1, 1944, an inventory of all demorol on hand July 1, 1944. Forms for this purpose have been mailed to all registrants.

Dr. Markwith Retires as Director of Ohio Department of Health

Dr. R. H. Markwith retired as director, Ohio Department of Health, on August 21 when his five-year term expired, to become assistant medical director of the clinical laboratory owned and operated by Dr. Anson L. Brown, 327 East State Street, Columbus.

Dr. Markwith had served as state director of health since January, 1939, when he was appointed to that position by Governor Bricker. When the law enacted by the Legislature in 1939, reorganizing the Ohio Department of Health and providing for a five-year term for the director, became effective in August, 1939, Dr. Markwith was reappointed by the Governor. Prior to becoming state director of health, Dr. Markwith had served as health commissioner of Summit County.

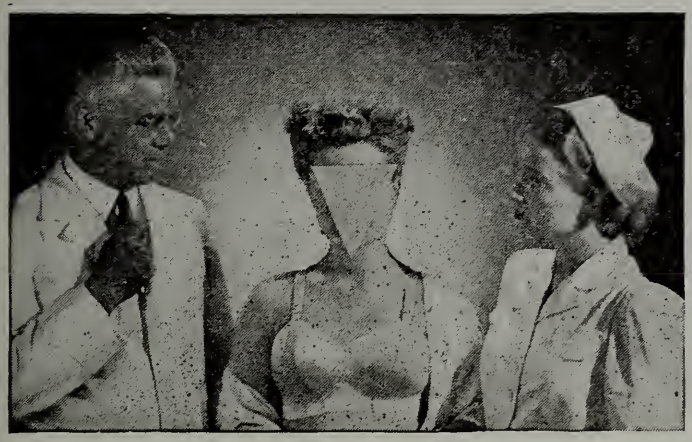
Successor to Dr. Markwith will be named by Governor Bricker as soon as the Ohio Public Health Council submits to him the names of five qualified physicians from which he can make a selection. The law requires the Governor to appoint the director of health from a list of five nominees submitted by the public health council.

Until a new director is named by the Governor, the department will be in charge of Mr. James E. Bauman, assistant director and chief of the legal division.

On September 14, during the annual meeting of the American Association for the Advancement of Science, in Cleveland, Alpha Epsilon Delta, a national honorary premedical fraternity, will hold a special program on premedical education. Among the speakers will be Dr. Victor Johnson, secretary, Council on Medical Education and Hospitals of the American Medical Association, and Hugh E. Setterfield, Ph.D., premedical adviser, Ohio State University, and president of the fraternity.

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Outstanding Program for Northwestern Ohio Meeting At Findlay, October 3, Arranged

AN outstanding program has been arranged for the 100th meeting of the Northwestern Ohio Medical Society, Tuesday, October 3, at the Elks Club, Findlay. All Ohio physicians are cordially invited to attend.

Registration will begin at 9:30 A.M. (Findlay time is one hour faster than State time.) There will be two lectures in the morning, beginning at 10:30 o'clock and three in the afternoon, beginning at 2 o'clock. The talks will last 45 minutes. In addition, there will be an address at the luncheon by Dr. Walter C. Alvarez, Mayo Clinic, Rochester, Minn., on "Hints in the Recognition of Puzzling Abdominal Pain".

The five other speakers are members of the faculty of the University of Cincinnati College of Medicine. The titles of their papers follow:

"The Toxic Reactions of the Newer Sulfonamides", Dr. Marion A. Blankenhorn, professor of medicine.

"The Child Who Won't Eat", Dr. A. Ashley Weech, professor of pediatrics.

"Some Common Foot Disabilities in Children and Adults", Dr. Joseph A. Freiberg, associate professor of orthopedic surgery.

"Tests of Liver Functions in Health and in Disease", Dr. Leon Schiff, associate professor of medicine.

"Penicillin—the Management of Surgical Infections", Dr. William A. Altemeier.

Officers of the Society are: Dr. W. B. Recker, Leipsic, president; Mr. Martin W. Diethelm, Toledo, vice-president; Dr. John M. Leahy, Tiffin, secretary; Dr. E. L. Brady, Marion, treasurer. Program arrangements are in charge of Dr. Frank M. Wiseley, Findlay.

Coming Meetings

Aero Medical Association of the United States, St. Louis, Sept. 4-6.

American Hospital Association, Cleveland, Oct. 2-6.

American Pediatric Society, Atlantic City, Sept. 25-27.

American Public Health Association, New York, Oct. 3-5.

American Roentgen Ray Society, Chicago, Sept. 24-29.

Radiological Society of North America, Chicago, Sept. 24-29.

American Congress of Physical Therapy, Cleveland, Sept. 6-9.

Association of Military Surgeons of the United States, New York City, Nov. 2-4.

International College of Surgeons, United States Chapter, Philadelphia, Oct. 3-5.

Northwestern Ohio Medical Society, Findlay, Oct. 3.

Columbus—Dr. C. C. Sherburne spoke on "The Question of Socialized Medicine" at a meeting of the Optimist Club.

Resigns as Chief Actuary

After 23 years as chief actuary for the State Industrial Commission, and six years previously as assistant actuary, E. I. Evans has resigned to go in business for himself. With Paul Grube, Cleveland, a former associate at the Commission and now vice-president of Industrial Advisers, Mr. Evans has formed E. I. Evans & Co., with offices in Columbus, to serve as consulting actuaries on workmen's compensation, unemployment insurance and wage stabilization. Walter J. Mackey, Columbus attorney, and former member of the board of review of the Bureau of Unemployment Compensation, will act as general counsel for the firm and adviser on unemployment compensation matters.

A total of 2,876 Ohio physicians have participated in the program of the U.S. Children's Bureau for the emergency maternity and infant care of wives and children of enlisted men, since its inception in Ohio on August 12, 1943. Maternity bills of 21,119 service men's wives were paid at a cost of $1,240,690 for hospitalization and $925,195 for medical care.

The Fall examinations of the State Medical Board will be held at Columbus, Sept. 26-29.



For symptoms caused or accompanied by gastric hyperacidity

Creamalin promptly reduces stomach hyperacidity by adsorption. The effect is persistent. It does not provoke a secondary rise in hydrochloric acid, such as is common after alkalies, nor does it disturb the acid-base balance of blood plasma. . . . Relief is promptly secured and maintained with safety. Hence the very extensive application of this highly useful agent in the management of peptic ulcer and symptoms caused by gastric hyperacidity.

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Increase Made in Military Roster; 2,894 Ohio Physicians Now on Active Duty Check-Up Reveals

ADDITIONS made to the Military Roster of the Ohio State Medical Association during the past month increased the total number of Ohio physicians in the services to 2,894, including 2,437 in the Army, 390 in the Navy and 67 in miscellaneous governmental services. Some of the men whose names have been added to the Military Roster have been in the service for a considerable time but this information was just received by the State Association. The names of such men are designated with a star (*) in the appended list of names added to the roster. Many of the men whose names appear on the roster for the first time were interns or residents serving in Ohio hospitals and who recently were called for active duty.

NAMES ADDED TO MILITARY ROSTER

Name	City	Rank
Auringer, Arthur J.	East Cleveland	Lt. (j.g.) U.S.N.
Beachler, J. F.	Cleveland	1st Lt., U.S.A.
Berger, Benjamin	Cleveland	1st Lt., U.S.A.
Bobbio, Joseph P.	Warrensville	1st Lt., U.S.A.
Boehmer, Henry E.	Cleveland	1st Lt., U.S.A.
*Book, Donald	Cleveland	1st Lt., U.S.A.
*Bramley, Howard F.	Cleveland	1st Lt., U.S.A.
Burry, Robert O.	Cleveland	Lt. (j.g.), U.S.N.
Ceraldi, Bernard A.	Cleveland	1st Lt., U.S.A.
Clark, Willard C.	Dayton	Lt. Comdr., U.S.N.
Cohen, Benjamin R.	Cleveland	1st Lt., U.S.A.
*Cooper, Frederick Paul	Cleveland	1st Lt., U.S.A.
DePiero, Nicholas	East Cleveland	1st Lt., U.S.A.
Derr, John Wm.	Cleveland	1st Lt., U.S.A.
Diefendorf, Herbert W.	Cleveland	1st Lt., U.S.A.
*Dorton, David, Jr.	Springfield	1st Lt., U.S.A.
*Dowling, Charles V.	Cleveland	1st Lt., U.S.A.
*Dugan, Robert J.	Cleveland	1st Lt., U.S.A.
*Finke, Frederick C.	Columbus	1st Lt., U.S.A.
*Fintz, Ralph J.	Cleveland	1st Lt., U.S.A.
*Foertmeyer, Chas. H.	Cincinnati	1st Lt., U.S.A.
*Frommeyer, Walter,	Cincinnati	1st Lt., U.S.A.
*Geiser, Frank M.	Cleveland	1st Lt., U.S.A.
Gibson, E. T.	Cleveland	1st Lt., U.S.A.
Graham, John H.	Hinckley	1st Lt., U.S.A.
*Hargett, Herbert	Springfield	1st Lt., U.S.A.
Haynes, Harley A.	Akron	Lt., U.S.N.
*Hemphill, James E.	Cleveland	1st Lt., U.S.A.
*Henry, Robert	Columbus	Lt. (j.g.), U.S.N.
*Hilsinger, Raymond L.	Cincinnati	Lt., U.S.N.
*Hoffman, Harry P.	East Cleveland	Lt. (j.g.), U.S.N.
Holmes, Joseph H.	Fremont	Capt., U.S.A.
Humel, Edward J., Jr.	Cleveland	1st Lt., U.S.A.
Jones, Mason Scott	Columbus	1st Lt., U.S.A.
Kent, Gerald T.	Cleveland	1st Lt., U.S.A.
King, L. H.	Cleveland	1st Lt., U.S.A.
*Kipp, Dean C.	Columbus	Lt. (j.g.), U.S.N.
*Kirk, Robert C.	Cleveland	1st Lt., U.S.A.
Koehler, R. S.	Dayton	Lt., U.S.N.
*Koenigshoff, John A.	Cleveland	1st Lt., U.S.A.
Kohn, Paul M.	Cleveland	1st Lt., U.S.A.
Laufer, Maurice W.	Yellow Springs	1st Lt., U.S.A.
*McCaffery, Eugene J.	Cleveland	Lt. (j.g.), U.S.N.
*McCain, French	Cleveland	1st Lt., U.S.A.
*Meads, Garner B.	Cleveland	1st Lt. U.S.A.
*Messina, John	Cleveland	1st Lt., U.S.A.
*Montgomery, Paul W.	Cleveland	1st Lt., U.S.A.
Morell, Clarence J.	Cleveland	1st Lt., U.S.A.
O'Hare, James E.	Cleveland	1st Lt., U.S.A.
*Owen, Wm. F.	Cleveland	1st Lt., U.S.A.
*Parker, Lester	Cleveland	Lt. (j.g.), U.S.N.
Phillips, C. A.	Toledo	Capt., U.S.A.
Posey, Frank M.	Cleveland	Lt. (j.g.), U.S.N.
Reimers, Wilbur L.	Columbus	1st Lt., U.S.A.
*Renner, Wm. J.	East Cleveland	Lt. (j.g.), U.S.N.
Rosenberg, Norman J.	Cleveland	1st Lt., U.S.A.
*Rosier, Harold A.	Cleveland	1st. Lt., U.S.A.
Schilke, Elliott W.	Springfield	1st Lt., U.S.A.
Sherrick, Joseph C.	Cleveland	1st Lt., U.S.A.
Shreve, Robert W.	Cleveland	1st Lt., U.S.A.
*Smith, Miles Beeman	Cleveland	1st Lt., U.S.A.
Stack, Gerald Alten	Cleveland	Lt. (j.g.), U.S.N.
*Stillson, Dean E.	Cleveland	1st Lt., U.S.A.
Stokien, Ernest D.	Cleveland	1st Lt., U.S.A.
*Strauss, David A.	Cleveland	1st Lt., U.S.A.
Sudimack, George A.	East Cleveland	Lt. (j.g.), U.S.N.
Thommason, Leslie H.	Wellington	Lt. (j.g.), U.S.N.
*Todd, Gordon M.	Cleveland	1st Lt., U.S.A.
Waltz, Frederick A.	Columbus	1st Lt., U.S.A.
Weisberger, Austin S.	Cleveland	Lt. (j.g.), U.S.N.
Wells, William M.	Columbus	1st Lt., U.S.A.
Winter, Andrew A.	Toledo	1st Lt., U.S.A.
Woodworth, Jess J., Jr.	East Cleveland	Lt. (j.g.), U.S.N.

WIN PROMOTIONS

Baurichter, F. P.	Cincinnati	Lt. Comdr., U.S.N.
Burrows, John W.	Erie Beach	Capt., U.S.A.
Beshara, Edmund F.	Cleveland	Major, U.S.A.
Byrne, Thomas E.	Mentor	Lt., U.S.N.
Christman, H. E.	Cleveland	Lt., U.S.N.
Curran, Thomas R.	Columbus	Major, U.S.A.
DeWeese, Marion S.	Kent	Major, U.S.A.
Dickson, Ross D.	Gibsonburg	Capt., U.S.A.
Dillahunt, Paul H.	Columbus	Major, U.S.A.
Flax, Ellis	Cincinnati	Capt., U.S.A.
Haas, Leonard J.	Cleveland	Capt., U.S.A.
Haas, Max	Cincinnati	Capt., U.S.A.
Hagen, John S., Jr.	Cincinnati	Major, U.S.A.
Hellwig, Edw. Frank	Cleveland	Major, U.S.A.
Kerns, Henri A.	Kenton	Capt., U.S.A.
Kessler, Morris M.	Cleveland Heights	Major, U.S.A.
Kubiac, Willis T.	Lancaster	Capt., U.S.A.
Kumpe, Carl W.	Hillsboro	Major, U.S.A.
Maryanski, Wm. Howard	Akron	Major, U.S.A.
Minge, Raymond K.	Cleveland	Capt., U.S.A.
Nusbaum, F. W.	Chillicothe	Lt., U.S.N.
O'Dea, Frank J.	Cleveland	Capt., U.S.A.
Peters, Geo. S.	Massillon	Lt. Comdr., U.S.N.
Reed, Lewis K.	Youngstown	Major, U.S.A.
Renner, George	Cincinnati	Lt. Col., U.S.A.
Schroeder, Raymond H.	Quincy	Capt., U.S.A.
Selfman, Albert	Mansfield	Capt., U.S.A.
Sherrer, Edward L.	Cleveland	Lt. Col., U.S.A.
Stager, Walter R.	Dover	Major, U.S.A.
Tirey, James W.	Anna	Capt., U.S.A.
Underwood, Homer D.	Van Wert	Capt., U.S.A.
Williams, Lester L.	Mt. Vernon	Capt., U.S.A.
Wiseman, G. R.	Amherst	Lt. Comdr., U.S.N.

TABULATION BY COUNTIES

Adams	2	Guernsey	6	Muskingum	9
Allen	37	Hamilton	432	Noble	1
Ashland	12	Hancock	13	Ottawa	9
Ashtabula	17	Hardin	7	Paulding	2
Athens	11	Harrison	4	Perry	4
Auglaize	6	Henry	3	Pickaway	5
Belmont	14	Highland	8	Pike	2
Brown	4	Hocking	4	Portage	2
Butler	30	Holmes	2	Preble	7
Carroll	1	Huron	16	Putnam	6
Champaign	9	Jackson	1	Richland	38
Clark	36	Jefferson	29	Ross	24
Clermont	9	Knox	11	Sandusky	12
Clinton	8	Lake	18	Scioto	20
Columbiana	11	Lawrence	6	Seneca	12
Coshocton	4	Licking	17	Shelby	7
Crawford	9	Logan	8	Stark	98
Cuyahoga	734	Lorain	40	Summit	149
Darke	6	Lucas	162	Trumbull	27
Defiance	4	Madison	6	Tuscarawas	20
Delaware	7	Mahoning	118	Union	2
Erie	10	Marion	16	Van Wert	9
Fairfield	9	Medina	13	Vinton	2
Fayette	2	Meigs	3	Warren	4
Franklin	239	Mercer	6	Washington	8
Fulton	6	Miami	13	Wayne	14
Gallia	5	Monroe	1	Williams	8
Geauga	4	Montgomery	153	Wood	18
Greene	7	Morgan	3	Wyandot	3

Total 2894

The Development of PENICILLIN *Schenley*



ONE of the most important phases of Schenley enterprise has long been extensive research on mycology and fermentation processes.

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Non-toxicity in therapeutic dosage is one of the most valuable features of penicillin. It is most important, of course, that the finished drug be uniformly free of pyrogens. PENICILLIN *Schenley* is produced under precautions for sterility more rigid than those taken in the most modern surgical operating rooms, and each lot is biologically tested before release.

•

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WAR NOTES

"Well, here I am riding along on a Navy ship, sitting over a thousand tons of explosives, listening to the gun crews having target practice overhead, and bound for duty in Australia", writes Comdr. H. P. Worstell, Columbus, previously at the Navy Pre-Flight School, Iowa City. Commenting on a stop-over in New Guinea, Dr. Worstell continues: "There is a place for you. They have 164 inches of rain a year and this is the rainy season. They say when you can see the tops of the mountains, it is going to rain, and when they are obscured by clouds, it is raining." Drought-scorched Ohio could surely use some of that moisture, doctor.

* * *

A veteran of the Canadian Army in World War I, Capt. S. W. Lord, Somerset, was one of the first Ohio medical officers to volunteer for service in the present war. After two years in combat with an armored infantry outfit in the African and Italian campaigns, he is now a convalescent patient at the Army and Navy Hospital, Hot Springs, Ark.

* * *

Capt. Dow Allard, Portsmouth, was home recently on 17-day leave from Alaska, where he has been with the Transportation Corps for 18 months. About 17 months were spent in an isolated area, where for 11 months he was CO of first a numbered station hospital, then of a port station hospital, of which he also became assistant port surgeon, and after a few weeks, port surgeon. "Back to civilization", his latest assignment is port surgeon at Juneau.

* * *

Major Marvin Sadugor, Cleveland, is back in this country after 26 months in the South Pacific, including the Fijis and Guadalcanal. He is taking a course in aviation medicine at Randolph Field, Texas.

* * *

Capt. C. K. Clippinger, Dayton, has a busy assignment with a station hospital in England. He is chief of the Out-Patient and Dispensary Service, Receiving and Disposition Officer, and also runs the sick call and pharmacy. Capt. Frank G. Lawyer, Cambridge, is his roommate.

* * *

After a short period with a station hospital in Italy, Major Carr E. Dix, Columbus, has returned to his old outfit—a general hospital unit in North Africa.

Capt. David Yospur, Gallipolis, is with a railway operation battalion in France.

* * *

From somewhere overseas with an infantry battalion, Capt. G. P. Fitzgerald, Springfield, V-mails his appreciation of receiving *The Journal* and continued membership in the Ohio State Medical Association. Three other Ohio medical officers in his outfit are: Lt. Chas. Foertmeyer and Lt. Wally Frommeyer, Cincinnati, and Lt. Kenneth Cowdrey, Sandusky. A battalion surgeon, Capt. Fitzgerald compliments the MAC officers who are now doing the administrative end of the work. He reports the following on some of his 1942 classmates at Ohio State: Andy Owens, Youngstown, Gorgas Hosp., Panama; Vince Peiffer, Genoa, USPHS, Washington; Jim Pollack, Columbus, with paratroops in Australia; Dean Mallett, Springfield, Camp Maxie, Texas.

* * *

Lt. Olan P. Burt, Columbus, is a member of the staff of the Station Hospital, Bradley Field, Conn. He was in on the care of the victims of the Hartford circus fire, the entire staff being rushed to the scene shortly after the tragedy occurred.

* * *

Major Edward F. Hellwig, Cleveland, now assistant wing surgeon and medical inspector for the AAF at Colorado Springs, has been in the service since May, 1941. His first assignment was in Panama, after which he was sent to the Galapagos Islands, off the coast of Ecuador. He returned to the States last July.

* * *

Capt. W. K. Brubaker, Elyria, is with the Vanderbilt Hospital unit in Italy.

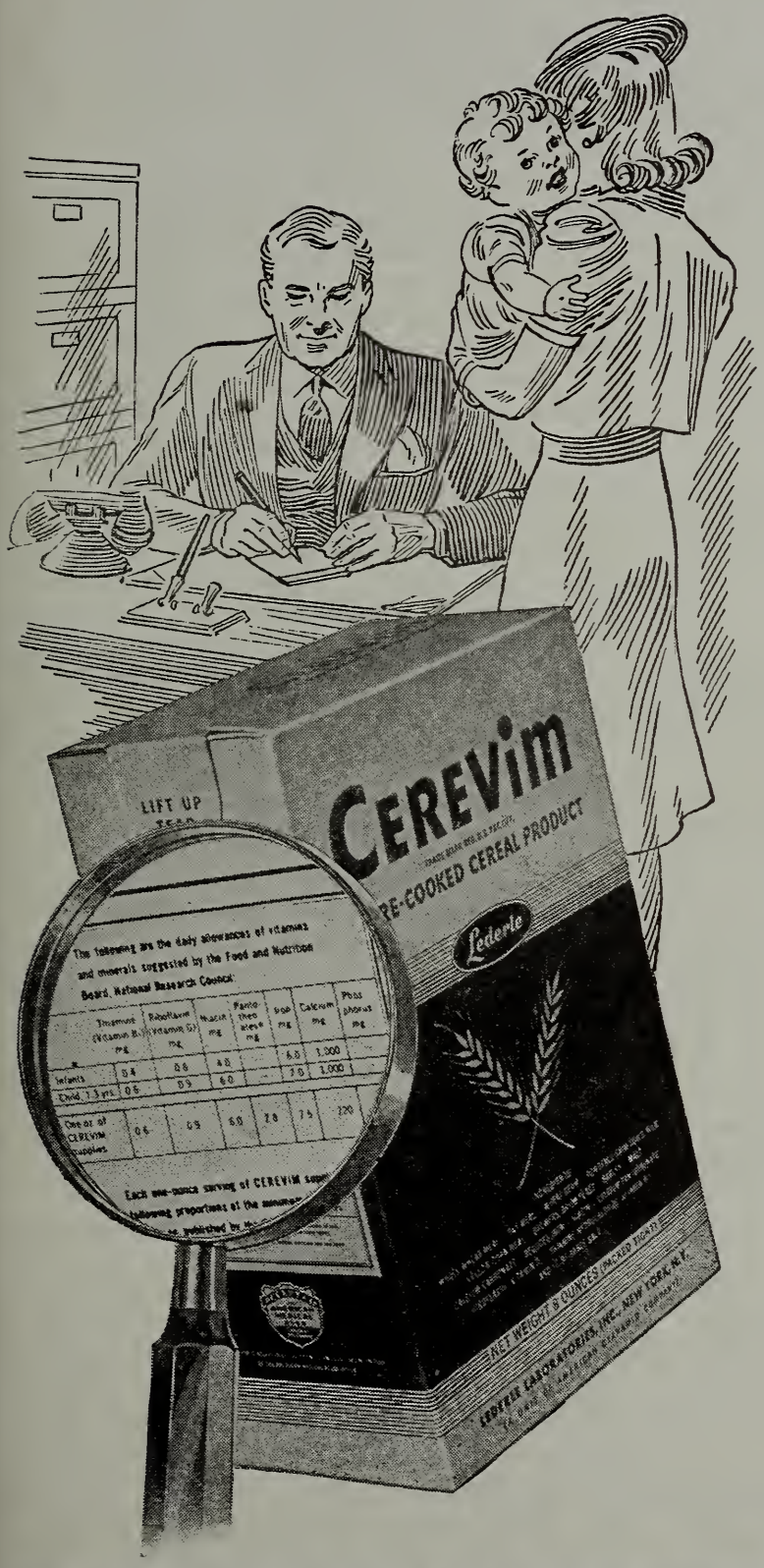
* * *

A number of Cincinnati medical officers participated in a broadcast recently over WLW, Cincinnati, from a base hospital in England. They included: Lt. Col. George Renner, Jr., chief of medicine for the unit; Lt. Col. H. J. Nimitz, executive officer; Major Jean Stevenson, chief of surgery, and Capt. Max Haas, ward surgeon.

* * *

Miscellaneous news about Columbus medical officers: Capt. Edward G. Klopfer, home on leave after two years with the 37th Div., in the South Pacific. . . . Lt. (j.g.) Paul Grimm, at a Naval Base Hospital in England, saw Capt. Peter Volpe recently in London. . . . Now as-

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CEREVIM HAS BEEN FORMULATED by authorities on nutrition as a very important article of the diet for an important member of the household, the baby. In deciding its content many questions arose—

Should it contain cereal grains? Whole wheat meal, oat meal, wheat germ, yellow corn meal and barley were added.

Should it include protein of high biological value? Dried skimmed milk, one of the best sources of such protein, was added.

Should it include natural vitamin B complex? Dried brewers' yeast was added.

Should it contain additional vitamins to make sure of ample supply? Thiamine hydrochloride (B_1), riboflavin (B_2) and niacin (anti-pellagra factor) were added.

Should it contain added iron and calcium? Both were introduced into the formula.

Was this an ideal balance of nutrient vitamins and minerals? It was put to the test of microbiological assays, chemical analysis, animal feeding experiments, and then compared carefully with the daily vitamin allowances recommended by the Food and Nutrition Board of the National Research Council. It met these tests easily.

CEREVIM has been found highly satisfactory in

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signed to a general hospital in Italy, Lt. Col. A. A. Hall had the pleasure of visiting Naples, Mt. Vesuvius and ancient Pompeii. . . . Capt. O. L. Coddington, battalion surgeon for a Long Tom artillery outfit in France, is getting used to crawling into a fox hole for a night's rest.

* * *

Major Edmund Beshara, Cleveland, is in charge of a dispensary for special troops at a divisional headquarters in Normandy.

* * *

Because he fell into the water when disembarking from a heaving landing craft during the invasion of France on D-Day, his life was undoubtedly saved, Capt. Albert Selfman, Mansfield, wrote to his wife, enclosing a Purple Heart awarded for "insignificant" wounds received in action. He is with the 29th Infantry Division.

* * *

With a station hospital in England, Capt. Foster M. Williams, Cincinnati, is quartered in "an old swanky girls' school". For five weeks after D-Day he was in a tent.

* * *

Lt. F. W. Nusbaum, Chillicothe, overseas since January, 1944, is chief surgeon of an amphibious unit in the South Pacific.

* * *

Major W. R. Stager, Dover, is in the Aleutian area. He was recently promoted to his present rank.

* * *

Invalided home from New Guinea, Major Leslie M. Buckner, Cincinnati, is a patient at Crile General Hospital, Cleveland.

* * *

Lt. Col. Earl Rosenblum, Steubenville, is assistant flight surgeon of a 9th Air Force Service Command Advanced Depot in the ETO. A veteran of more than two years in that area, Col. Rosenblum was formerly flight surgeon for the 9th Bomber Command, and earlier was attached to the 3rd Bomber wing, 8th Bomber Command, one of the first units to bomb occupied Europe. His brother, Capt. H. M. Rosenblum, also is in the ETO.

* * *

Lt. Col. Joseph M. Hayman, Jr., Cleveland, chief of the medical service for the Lakeside Hospital Unit, was home on leave recently. This general hospital unit, after nearly two years in Australia, is now located in New Guinea.

* * *

Senior medical officer at the Navy's bureau of supplies and accounts in his home-town, Cleveland, is the new assignment of Lt. Comdr. George J. Greene, recently returned from a tour of duty as medical officer for a submarine squadron in the South Pacific.

Major John T. Fawcett, Elyria, is post surgeon at the AAF Convalescent Center, Albuquerque, New Mexico.

* * *

When a bomb fell on a Southern English town recently, causing 11 deaths and a number of other casualties, a Columbus physician, Capt. A. C. Wyker, received praise from the townsfolk for his heroism in rendering assistance, according to news dispatches. It was stated that at the risk of his life he crawled under the wreckage where people were buried, giving injections to all he could find.

* * *

Capt. Carl F. Wagner, Cincinnati, has been appointed group flight surgeon of a medium bombardment group at an advanced base of the 13th Air Force in the South Pacific. He has flown on 16 combat missions, and has received the Air Medal and Oak Leaf Cluster. Capt. Wagner held a civilian pilot's license and owned his own plane before entering military service.

* * *

Two Ohio physicians on the staff of Bushnell General Hospital, Brigham City, Utah, appeared on the program of the Utah State Medical Association, August 25-26, at Salt Lake City. Major Max T. C. Schnitker, Toledo, spoke on "Osteomyelitis of the Skull—Its Treatment with Penicillin", and "Repair of Defects with Tantalum Plate". Major Clyde S. Roof, Cincinnati, discussed "Indications for the Use of Various Intravenous Solutions".

* * *

Lt. Col. Hardy A. Kemp, Columbus, on military leave from his post as dean of Ohio State University College of Medicine since March, 1942, gave the Alpha Omega Alpha lecture at Ohio State recently. His subject was "Medical Problems in the Burma-China Campaign". Col. Kemp is now secretary of the Army Medical Center, Washington, D.C. He was on active duty in the India-China-Burma theater for many months.

* * *

Changes of address within the continental boundaries of the United States: Lt. Wm. R. Liebschner, Deshler, Med. Pro. Unit, Maxfield, Ala.; Lt. Comdr. Graham R. Johnston, Medina, Naval Base, Port Huenema, Calif.; Major Chester H. Allen, Portsmouth, 1878th Unit, Sta. Hosp., Camp Claiborne, La.; Lt. Chas. G. Brown, Mansfield, Sta. Hosp., Ft. Belvoir, Va.; Major Wm. Compton, Greenhills, ASF Pers. Repl. Depot, Camp Beale, Calif.; Maj. Clyde J. Cranston, Wakeman, Sta. Hosp., 1580 S.U., Camp Campbell, Ky.; Capt. Wm. R. Chambers, Norwood, 9th Service Command, ASFTC, Ft. Lewis, Wash.; Capt. Paul Corso, Salem, SCU 1960, Hospital



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Trains Unit, Presidio of San Francisco, San Francisco, Calif.; Capt. Sam S. Chudde, Dayton, Med. Det., AAF, Palm Springs, Calif.; Capt Sidney L. Davidow, N. Jackson, 14th Field Hosp., Camp Bowie, Tex.; Lt. Col. Wallace S. Duncan, Cleveland Heights, Regional Hosp., Mitchell Field, Long Island, N.Y.; Lt. Ed Glicksberg, Cleveland Heights, Reg. Sta. Hosp., Ft. Leonard Wood, Mo.; Lt. W. L. Hann, West Unity, USN Amm. Depot, Dover, N.J.; Capt. Morris Hyman, Cincinnati, Sta. Hosp., Camp Croft, S.C.; Lt. Comdr. L. B. Hurless, Dayton, USN Advance Base, Personnel Depot, San Bruno, Calif.; Lt. Col. H. E. Harman, Chillicothe, Hotel Annapolis, Washington, D.C.; Lt. Col. Chas. E. Howe, Westerville, 155th Gen. Hosp., Nichols Gen. Hosp., Louisville, Ky.; Major Jos. C. Hayward, Columbus, Sta. Hosp., Camp Shelby, Miss.; Lt. Tom S. Levin, Cincinnati, USNAD, St. Juliens Creek, Portsmouth, Va.; Lt. Howard Lauer, Dayton, 8th Repl. Wing, AAF, Salt Lake City, Utah; Capt. F. W. Kaylor, Bellefontaine, Med. Det., 3rd Bn Bn., 166th Inf., Ft. Sill, Okla.

Major Ralph H. Leyrer, Hamilton, 430 Med. Dn., Ft. Ord, Calif.; Maj. A. H. Kimmel, Norwalk, AA Base, Charleston, S.C.; Lt. Comdr. Lester Laskey, Zanesville, c/o Dispensary, ATB Coronado, San Diego, Calif.; Lt. Col. H. L. Mikesell, West Liberty, Camp Campbell, Ky.; Capt. M. I. Marks, Cleveland, Tyndall Field, Fla.; Maj. J. M. McNamee, Cleveland, AAF Regional Sta. Hosp., Hunter Field, Savannah, Ga.; Capt. J. J. Maggiore, Canton, 643 AAA (AW) Bn., Ft. Bliss, Texas; Lt. W. N. Macey, Cleveland, Beach Bn. School, Oceanside, Calif.; Major C. E. Northrup, McConnelsville, 163rd Gen. Hosp., Camp Grant, Ill.; Lt. Col. York Pitkin, Cleveland, ASFTC, Ft. Lewis, Wash.; Capt. Burman H. Preston, Cincinnati, Sta. Hosp., Camp Howzie, Texas; Col. Philip P. Pease, Chardon, AAF Sta. Hosp., Seymour Field, N.C.; Lt. Maurice E. Stilwill, Canton, 162nd Gen. Hosp., Camp Grant, Ill.; Lt. Comdr. George S. Peters, Massillon, Navy V-12 Unit, Bethany, West Va.; Lt. Col. Walter S. Price, Phillipsburg, Hqs. Second Army, Memphis, Tenn.; Lt. Comdr. C. M. Spercher, Cleveland, USN Hosp., ATC, Corpus Christi, Texas; Lt. A. H. Steinberg, Toledo, Army and Navy Hosp., Hot Springs, Ark.; Capt. Theodore D. Sawyer, Crestline, Med. Det. Hqrs., XXII Corps, Camp Campbell, Ky.; Maj. E. I. Silver, Cleveland, 275th Inf., Camp Adair, Ore.; Capt. R. L. Tecklenberg, Lima, AAF Reg. Sta. Hosp., Davis Monthan Field, Tucson, Ariz.; Capt. H. O. Tagett, Rock Creek, Ord. No. 3, AAF, Goldsboro, N.C.

* * *

Major Robert C. Haubrich, Pataskala, stationed in the Marshall Islands, was recently named assistant flight surgeon of the Seventh Air Force Bomber Command.

The 134th F. A. Bn. of the 37th Division, returned to Camp Atterbury, Ind., from the South Pacific, is under observation for filiariasis, according to a press report from the Fifth Service Command. Officers said the disease had been found in only a small percentage of the 522 men, and added that the condition of none of the men is serious. Most of the men were to receive 21-day furloughs and probably will be returned to active duty after the observation period, the officers said.

* * *

Capt. Edward G. Klopfer, Columbus, is another medical officer of the 37th Division to receive the Bronze Star Medal for meritorious service in the South Pacific.

* * *

Capt. S. H. Galinson, Dayton, is with an Eng. Avn. Bn., somewhere out there in the Pacific.

* * *

Far, far away from his home town, London, Capt. J. A. Knapp, is with a general hospital unit in India.

* * *

Capt. Raymond H. Schroeder, Quincy, is flight surgeon for a fighter squadron in China.

* * *

Home on leave from the South Pacific, Capt. Earl E. Conaway, Cambridge, a flight surgeon, recently gave local Kiwanians a graphic picture of his experiences in that area. For nine months Capt. Conaway was engaged in aerial evacuation of casualties from the front lines. Then he contracted malaria and was hospitalized at a base hospital in Auckland, New Zealand. He has been awarded the Legion of Merit.

* * *

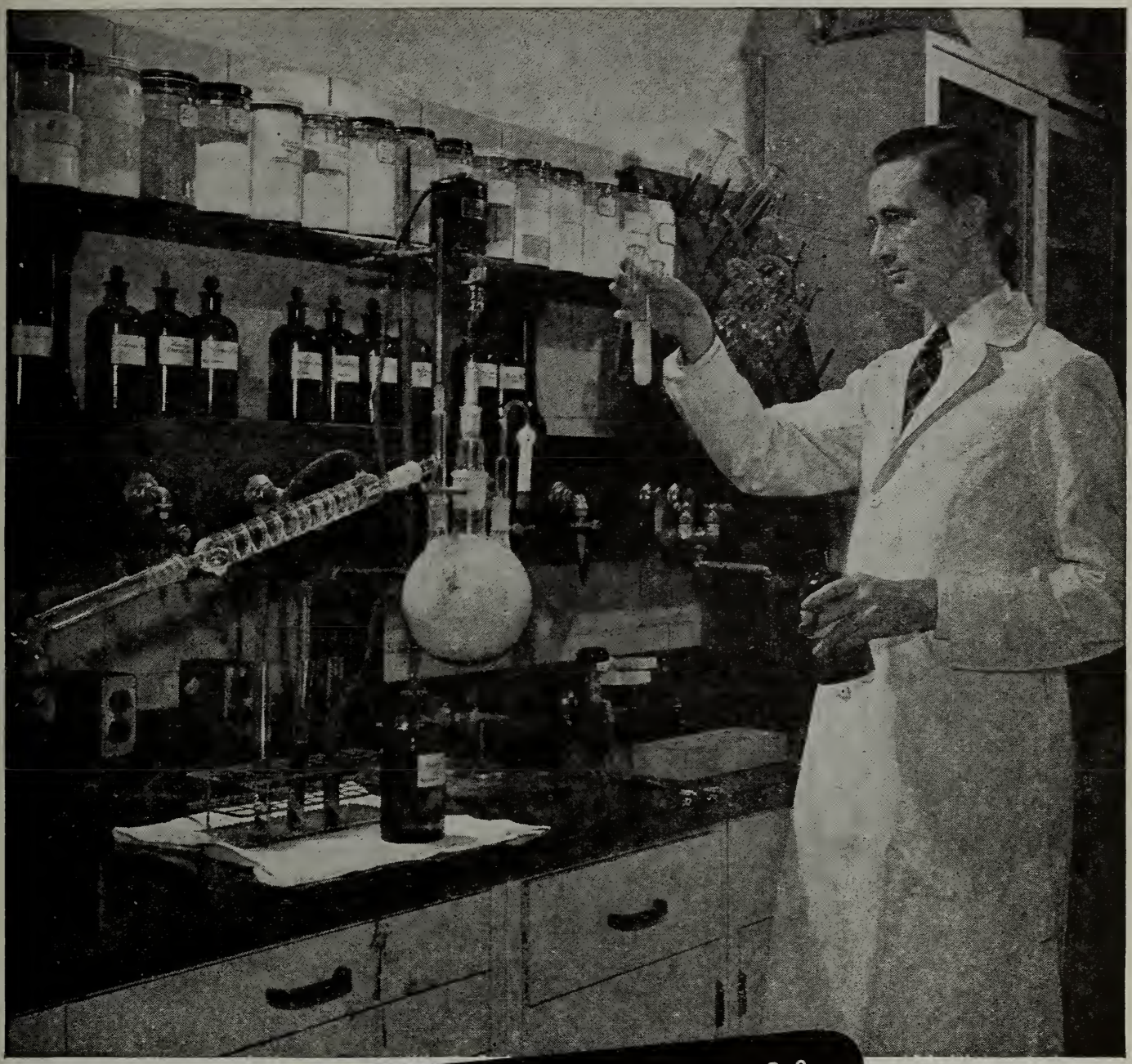
Recently detached from the U.S. Naval Hospital, San Diego, Lt. Raymond L. Hilsinger, Cincinnati, is doing ENT work at the Amphibious Training Base, Coronado, San Diego, Calif.

* * *

Back in England with a station hospital, Capt. W. T. Kubiac, Lancaster, reports "some very interesting experiences" on detached duty during the first two weeks of the Normandy invasion.

* * *

According to a press release from the Technical Information Service of the Office of the Surgeon General, Lt. Col. P. T. Knies, Columbus, was one of the speakers at a recent conference held in that office of 23 Army Medical Department officers who had completed the indoctrination course in civil affairs at the School of Military Government, Charlottesville, Va. These officers have been assigned for Far East background and public health training in the



WHAT ARE WE LOOKING FOR?

In arsenical research we are seeking compounds which offer promise of greater effectiveness against the spirochete of syphilis with less toxicity to the patient . . . a syphilis therapy that will be even better than the dramatically successful Mapharsen* treatment of today. But that is not all we are looking for... we are making an exhaustive study of arsenic compounds, searching for the one that may bring amebic dysentery and other diseases of protozoan origin under control, and open up new fields of effective therapeutics.

*Trade-mark Reg. U. S. Pat. Off.



PARKE, DAVIS & COMPANY DETROIT 32, MICHIGAN

Civil Affairs Training School at Yale University, New Haven, Conn. Col. Knies is on the staff of the International Quarantine Commission.

* * *

Capt. Lawrence C. Goldberg, Cincinnati, chief of the dermatology and syphilology section and chief of the neuro-syphilis center at Thayer General Hospital, Nashville, Tenn., contributes the following in response to our request in the August issue for news:

"It might be of interest to those who read *The Journal* to know what extent the Army is now going to treat syphilis, particularly neuro-syphilis. Centers have been established where final treatment and disposition of all cases of neuro-syphilis occurring in the Army will be made. Whether men are in India, China, Europe, the South Pacific or in the States, they will be sent to one of such centers for final disposition, evaluation or treatment. I have been fortunate in being selected as one of the chiefs of such a center and to date have seen a number of interesting and unusual cases. Another interesting part of this program is that those who are separated are followed to see that they continue treatment where it was left off."

* * *

Lt. Ben E. Jacoby, Columbus, Navy flight surgeon, has been awarded the Silver Star and the Purple Heart for gallantry in action during the bombing of naval forces by Japanese planes in the Marshall Islands last February. A native of Marion, Dr. Jacoby was a resident in obstetrics at White Cross Hospital, Columbus, before entering the Navy.

* * *

Around the world with Cleveland medical officers: Capt. R. K. Minge, on the Normandy beachhead, wrote July 1: "One of the captured German officers said Germany could not hold out 90 days. I hope that is correct". . . . Lt. Col. E. L. Sherrer, with a station hospital on the Aleutians, says it's been a long time away from home, but things look pretty good now . . . On the high seas with the Fifth Amphibious Corps, Fleet Marine Force, Lt. W. A. Nosik writes: "Have been assigned to one of three 'Flying Specialist Teams'. Each team has five men, a neurological surgeon, a general surgeon, an orthopedic surgeon, an eye man and a maxillofacial surgeon. We expect to see plenty of action" . . . Lt. A. H. Schumacher, with a fleet hospital on the Solomon Islands, observes: "We are out of the mud, with wonderfully good coral roads that would be a credit to some parts of Ohio. The front has moved farther and farther away, but we have a good supply of X-ray work, and I operate the department and am my own maintenance man. The other Cleveland doctor here is Dr. Disbro, of Charity Hospital, and Dr. Stack of Lorain is nearby on the same island" . . . Capt. Len J. Haas, also in on the Normandy invasion, says: "We were the only hospital in that area for four days. An evacuation hospital came on D-4 and functioned D-5. Those four days and nights were a hell of constant work" . . . Also with a medical battalion in France, Capt. Henry P. Limbacher has procured a number of souvenirs, including a large new German flag . . . Capt. Jim E. Morgan is at Recife, Brazil, with a station hospital, eight degrees below the equator but the trade winds keep them cool . . . Aboard ship in a very busy spot in the Pacific, Lt. Comdr. Tom V. Charvat writes that caring for a large number of casualties on ship with a sea running was something, but in addition, he got a wallop on his head which caused him to lose his glasses —all of which didn't help him any.

* * *

The Army Nurse Corps has lost 69 of its 40,000 members by death in the line of duty since the start of the war, according to a recent announcement by the War Department. In addition, 24 have been wounded and 66 are prisoners.

* * *

Lt. Comdr. Harve M. Clodfelter, Columbus, former Tenth District Councilor, sends greetings from the Marine Corps Air Station at Cherry Point, N.C., where he is chief of medical service. He has the following to report on some Ohio Naval medical officers: Lt. H. E. Christman, Cleveland, and Lt. Chas. S. Turville, formerly of Zanesville, attached to the Ninth Wing and on Dr. Clodfelter's medical service; Lt. Comdr. Guy Rowland, Cleveland, attached to the Ninth Wing and flight surgeon for one of the groups now at the outlying field at Kinston, N.C., but a subsidiary of Cherry Point; Lt. Comdr. F. P. Baurichter, Cincinnati, sanitation officer and in charge of the medical care of employes of the huge assembly and repair shops at Cherry Point; Lt. Comdr. Orville Wright, Dayton, in charge of the Dependents Outpatient Dept.; Lt. Daniel Feiman, Canton, after a year at Cherry Point, recently transferred to active flight surgeon duty with the fleet.

* * *

According to the April issue of *Women in Medicine*, up to that time 48 women physicians had been commissioned in the Army, 27 in the Navy and 11 in the U.S. Public Health Service, a total of 86.

* * *

Brig. Gen. Charles C. Hillman is the new commanding general of Letterman General Hospital, San Francisco. He succeeds Brig. Gen. Frank T. Weed, who will soon retire.

Insulin action *timed* to the needs of the day



'WELLCOME' GLOBIN INSULIN WITH ZINC

● As the diabetic goes through the day, his insulin requirements vary. 'Wellcome' Globin Insulin with Zinc provides an action timed to meet these changing needs. An injection in the morning is followed by rapid onset of action which is sustained for continued blood sugar control as the day wears on. Finally by night insulin action begins to wane, minimizing the occurrence of nocturnal reactions.

Many moderately severe and severe cases of diabetes may be controlled with only a single, daily injection of 'Wellcome' Globin Insulin with Zinc. This new long acting insulin is a clear solution of uniform potency. In its freedom from allergenic skin reaction, it is comparable to regular insulin. This advance in diabetic control was developed in the Wellcome Research Laboratories, Tuckahoe, N. Y. U. S. Pat. 2,161,198.

Vials of 10 cc. 80 units in 1 cc.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WHEN WE EXAMINE, LET'S DO A REAL JOB!

Now that the government has become so keenly interested in the subject of physical fitness, we will hear more and more about reasons for and the merits of a periodic health examination. Certainly such examinations will play a big part in any or all physical fitness programs.

In reflecting, we have to admit the sad truth that the medical profession has never given as much support to periodic health examination programs as such procedures deserve. Periodically here in Ohio there has been a revival of such programs but they have never actually clicked. Now is the time for Ohio physicians to turn over a new leaf. We should prepare for demands which will be made upon us as soon as the physical fitness program gets into full swing.

Three points about the periodic health examination should be very clear to us:

First, we should realize that by a very simple but complete going-over, a physician can detect in a patient a goodly number of gross defects, not even suspected by the person examined. Among these defects are such things as diseased tonsils, decayed teeth and pyorrhea, allergic rhinitis, gross impairments of vision, bad posture and flat feet, hernias or enlarged rings, heart murmurs and disordered heart action, goiter, and suger in the urine. Some of these can be corrected. Where this is true, their correction will not only add to the efficiency of the individual but will, on the average, give him six additional years of life.

Unfortunately, those who want to get these potential patients into our offices are disturbed frequently because of the casual way in which some physicians make these investigations. These check-ups are not too complicated and do not take an unusual amount of time. A little more effort on the part of all physicians along this line would yield big returns in terms of public health, of more public confidence in the profession as a whole, and an increased clientele for more physicians.

Second, we should understand that almost all of the defects which have been mentioned are the result of poor nutrition coming largely from bad food habits. So, if we want to do away with them and with the expense of these examinations (and they will be very expensive to the taxpayer if the Federal Government sets up "examining centers"), we must continue the campaign to improve the nutrition of our people.

This nutritional campaign, if properly carried out, can make a great contribution to postwar economics. For example, do you know if every child under 14 years of age in this country were to get one quart of milk each day, that it would require more than 10 million additional cows, one million additional farm laborers, and the return of more than 40 million additional acres of farm land to production?

Third, physicians have neglected themselves badly in recent years. Many are pretty well worn out and physically unfitted to carry on present schedules. A fine contribution to the physical fitness program which physicians could make would be to get checked up themselves. Society has a right to ask that we do so, as society in the end has a big investment in us. Therefore, we owe it to ourselves, our families and to the public to lead in this campaign for the partial rehabilitation of defective and worn-out citizens by practicing good preventive medicine on ourselves. Let someone else do the preaching.

THERE IS ONLY ONE OFFICIAL, RECOGNIZED DIRECTORY

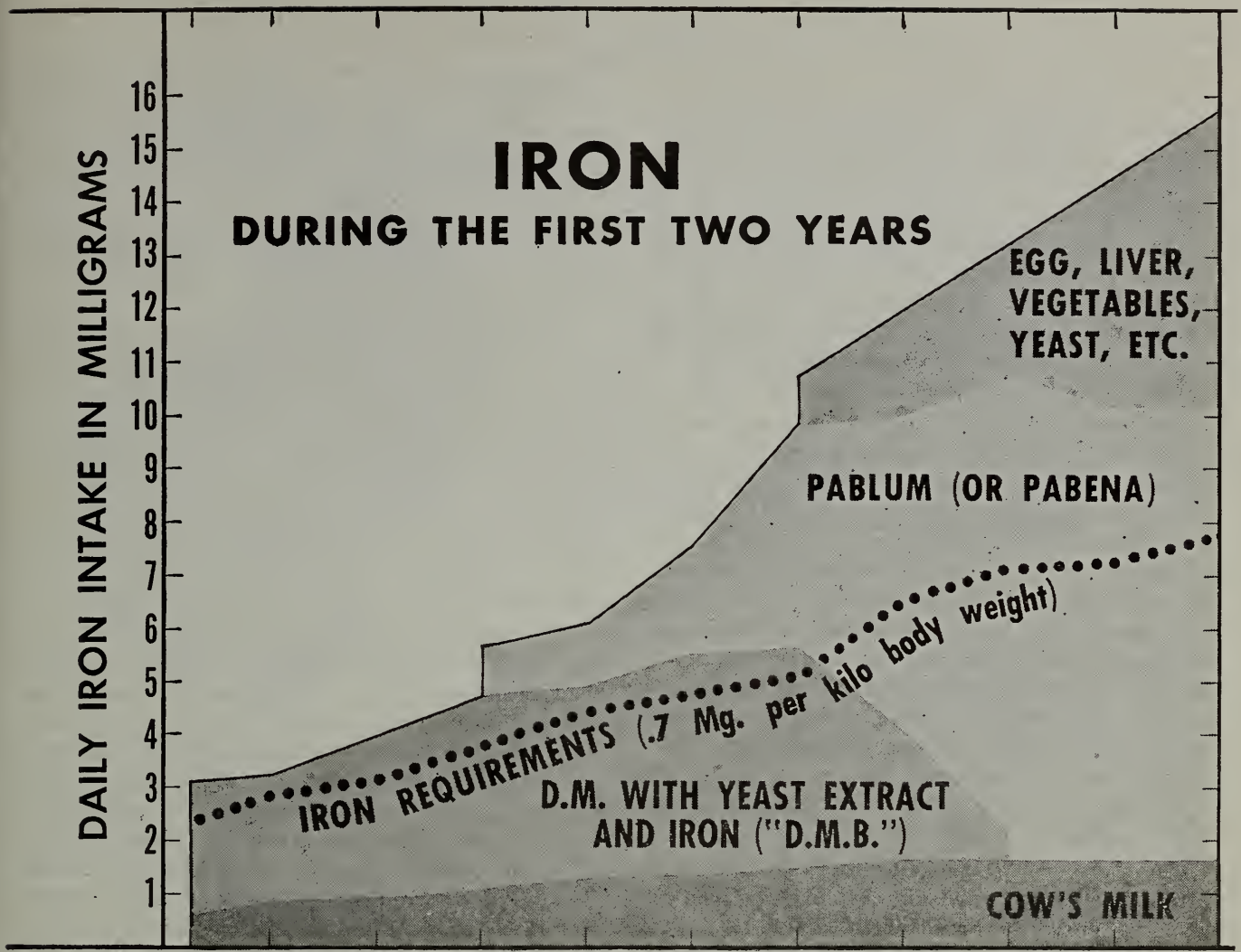
Ohio physicians have been receiving requests for biographical data and a photo from an organization said to be compiling a so-called "who's who" or directory of professional men.

Whether a physician submits his name and photo to such an organization is, obviously, his own business. But, he should keep in mind that such ventures are for profit and that in the end the only directory of physicians which is official and is recognized as such by most persons or organizations seeking accurate information on physicians is the American Medical Directory.

MEDICAL OFFICERS: HAVE YOU RETURNED QUESTIONNAIRE?

It is hoped that all Ohio physicians now in military service will cooperate with the American Medical Association in its efforts to obtain data which will be used as a basis for establishing an efficient postwar medical training for medical officers.

Obviously, the way to cooperate is for each medical officer to fill out and return to the A.M.A. as soon as possible the questionnaire which the A.M.A. has mailed to him. Efforts



AGE, Mos.	¼	1	2	3	4	5	6	9	12	18	24
WEIGHT, Lbs.	7	9	10	12	14	15	16	19	22	23	25
MILK, Oz.	10	16	18	21	24	26	28	32	32	32	32
"D.M.B.," Oz.	1	1	1¼	1½	1½	1¾	1¾	1	¼	0	0
PABLUM, Oz.	0	0	0	⅛	¼	¼	½	¾	1	1	1

IRON DURING THE FIRST TWO YEARS

During fetal life iron accumulates (in the form of hemoglobin) in the infant's body. After birth the hemoglobin frequently drops to 50% by the third month, especially in prematures. Neither breast milk nor cow's milk is capable of offsetting this loss, as they are deficient in iron. This chart shows that when the carbohydrate and cereal supplements contain iron, a sizeable margin of safety over the requirements can be maintained, not only during the important first six months, but throughout the first two years of life.

More iron than the calculated requirement is needed because some iron is not utilized. In rapidly growing, or poorly nourished infants, and in the presence of infection, the need for iron may be even greater than is indicated in this chart for normal infants.

MEAD JOHNSON & COMPANY, Evansville 21, Ind., U.S.A.

have been made to get a questionnaire into the hands of each of the 55,000 or more medical officers.

The Committee on Education of the Ohio State Medical Association is planning an active program to establish ample opportunities and facilities here in Ohio for Ohio medical officers who will want to take postgraduate or refresher work when relieved from active duty. Hospital and medical school officials are cooperating. Every effort will be made to set up educational programs of different kinds—long and short, resident and non-resident—for the benefit of returning Ohio doctors.

However, little can be done from a planning standpoint until something is known about the demand for the different types of educational work. For that reason the data which the A.M.A. hopes to receive will play a vital part in this enterprise. Information submitted by Ohio medical officers as to what their plans for the future are; what kind of postgraduate or refresher work they desire, etc., will be made available to the Committee on Education of the Ohio State Medical Association and will enable the committee to proceed with definite arrangements. Obviously the data can not be broken down and distributed to Ohio until it is received at the A.M.A. office in Chicago.

Therefore, each medical officer should return his questionnaire immediately. If he has not received one, he should write the A.M.A. for one. In doing so he will not only be helping himself but also cooperating in one of the most important undertakings ever attempted by medical organization.

REGARDLESS, THE REAL PROBLEM STILL EXISTS

The attorney general of the State of New York has ruled that concentrated vitamins can be sold at retail only by registered pharmacists and drug stores. It is indicated that grocers and department stores may appeal the ruling to the courts.

In our opinion the whole rumpus is silly. Does the average pharmacist know whether a bottle of vitamins should be sold to and taken by Mr. A? The evil of self-medication is fundamental, regardless of who does the selling of the product. Until the public learns that medicine, including vitamins, should be purchased and taken only upon the advice of a competent physician, rulings designating who can or can't sell it in package form, even though it may be properly labeled and manufactured by a reliable firm, will accomplish little in protecting the public against the consequences of its own faulty judgment.

IMPROVEMENTS IN COMMISSION'S PROCEDURES RECOMMENDED

A number of recommendations and criticisms relating to the present administration setup at the State Industrial Commission are made in a report recently completed by Joseph Froggatt & Company, Inc., New York, consulting actuaries and auditors, following an audit of the Ohio Workmen's Compensation Fund which must be made once every five years by statutory requirement.

Members of the medical profession will find that some of the observations made in the report are similar to suggestions and criticisms which have been voiced to the Commission on different occasions by the Ohio State Medical Association and individual physicians.

While this point is of interest, the more important one is whether anything can or will be done to attempt to correct some of the conditions referred to.

We are convinced that the Commission is willing to do everything within its power to make readjustments which will provide for more efficient administration. But, it must be recognized that some of the flaws in its operations can not be corrected merely by resolutions by the Commission. The Commission must be given the proper tools with which to work. More specifically, the Commission must be allotted more funds for administration and the wage and salary schedules covering employes of that department must be modified upward. If these two steps are taken, the Commission will then be able to employ better trained personnel and more personnel, and can supply such personnel with the new and up-to-date equipment which is necessary to carry on the work of the department.

Froggatt & Company point out that while the Commission is given the power to fix salaries or compensation, the expenses of administration are paid from appropriations of state funds by the General Assembly and therefore the Commission has to "cut its cloth" within these boundaries. Tribute is paid to the loyalty and "general efficiency" of the present staff but the opinion is expressed that "the staff now includes persons who lack the technical and/or educational background and/or experience necessary to maintain a proper standard of efficiency and intelligent handling of the work".

The actuarial company recommends that this situation should be corrected by legislation providing that administrative expenses shall be met from the Workmen's Compensation Fund which is made up of employer premiums.

"This would have benefits aside from enabling the Industrial Commission to pay adequate compensation to its present personnel and obtain proper technical and other personnel as needed,

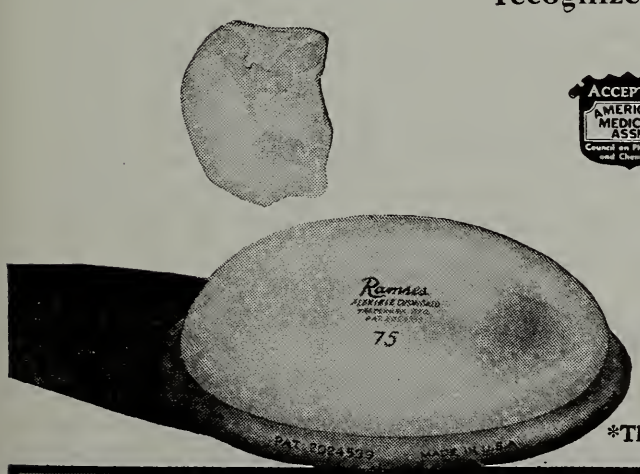


Accent on *Velvet Smoothness*

The process used in manufacturing the "RAMSES"* Flexible Cushioned Diaphragm produces a dome which is soft and pliable and can best be described as being as smooth as velvet.

This velvet-smoothness lessens the possibility of irritation during use.

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thereby improving the general efficiency of its organization", the report stated.

"It is obvious", the report continued, "that if required to contribute to the administrative expense, contributors, as a whole, will evidence greater interest in the efficiency of the administration".

The present housing facilities of the Commission are entirely inadequate for its needs and impairs the efficiency of the organization in the performance of its duties, Froggatt and Company observed.

On the matter of equipment, the report states that "the present equipment is in many respects antiquated, dilapidated and not suitable to the needs". Continuing it points out: "There also appears to be a dearth of satisfactory filing equipment and as a result papers and records are not fully safeguarded. * * * These conditions tend to breed inefficiency and carelessness aside from complications that might arise through loss or destruction by fire."

Froggatt and Company make the following comments regarding the handling of correspondence—a problem which has been the source of much complaint and criticism over a period of years:

"We also observed what appears to be an unwarranted delay in replying to correspondence and also instances where the replies were indefinite and did not furnish the specific information requested thereby necessitating additional correspondence that could be avoided. It is appreciated that this, to quite a degree, is caused by inadequate staff, cramped quarters, and the inexperience of employes due to the large 'turnover'. These conditions obviously add to the burdens of the Claims Section from many angles and we reiterate the need for definite prompt action along the lines previously suggested in an earlier section of this report.

"The importance of satisfactory and prompt adjudication of claims can not be overstressed, but obviously this can not be accomplished without recognition of the needs for an adequate staff of competent and efficient employes, and failure to recognize this will only add to the grief and burdens of all concerned. In order to handle the increasing number of claims without comparable increase in competent personnel, the Claims Section has had to 'streamline' its procedure in some respects which is neither desirable nor sound. Under the circumstances, the Claims Section has done remarkably well."

In addition to making certain suggestions on technicalities in the work of the various sections, the New York actuarial firm recommends "improved coordination of the integral parts so that the duties and responsibilities of the individual sections are more clearly defined and recognized".

"This is essential", the report states, "to eliminate duplication of effort; promote inter-departmental reliance and disseminate knowledge with respect to the relationship of each to the whole and the individual departmental requirements."

It is suggested that the Commission appoint a coordinator, directly responsible to the Commission and vested with supreme supervisory authority. The coordinator would provide for periodic meetings with the supervisory heads of the several sections who would act as an advisory committee to aid and assist in the formulating and execution of plans and ideas.

All of these suggestions should receive the sincere consideration of the Industrial Commission. Immediate steps should be taken by the Commission to put suggested improvements into effect if it is feasible for the Commission to do so at this time.

Obviously, legislation is necessary to bring about a change in methods of meeting administrative expenses which, in the final analysis, is the crux of most of the problems confronting the Commission.

Those who are sincerely interested in keeping the Workmen's Compensation System operating at the peak of efficiency should give this point serious thought. It is apparent that the Commission is in need of more money for operating expenses. Also, it is obvious that some of the big problems in the department can not be solved unless the Commission is more adequately financed.

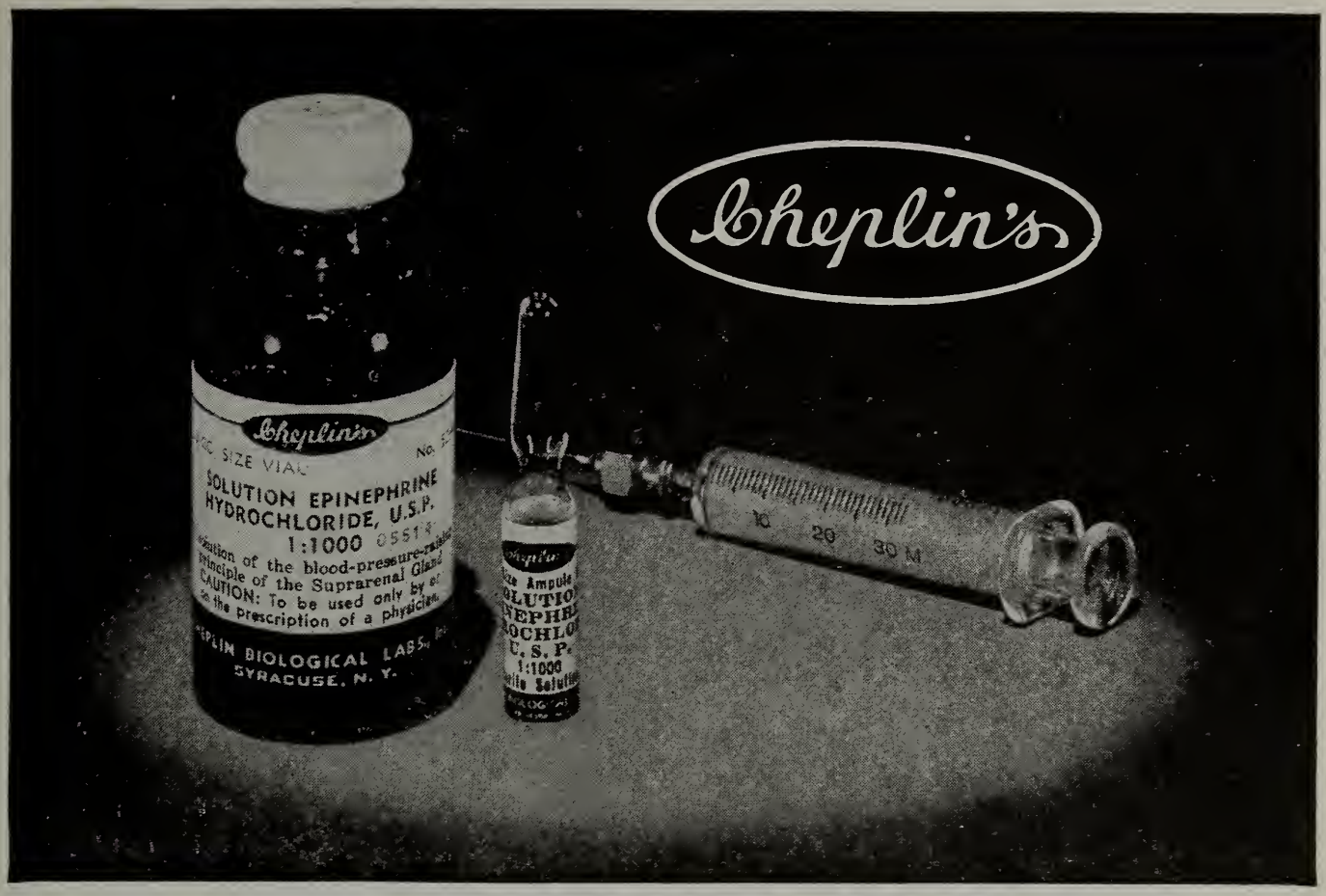
The suggestion made by Froggatt & Company that administrative expenses be paid from the contributors' fund should be brought to the attention of the General Assembly when it meets in 1945.

If such a change would produce improvements which the Froggatt firm recommends, legislation authorizing the new method should receive the active support of Ohio physicians. Many physicians have been critical of some of the office routine of the Commission. If legislation to improve conditions is presented to the Legislature, it is hoped that those who have criticized will take a personal interest in seeing that such legislation is enacted.

TEAMWORK IN DENTISTRY AND MEDICINE

A writer in *Medical Economics* states that many a dentist harbors the feeling that his medical acquaintances hold him in low esteem and complains about the physician's lack of regard for their personal dignity and professional pride.

If that is the majority opinion among members of the dental profession (we don't believe it is), then it's high time that something be done quickly



Epinephrine Hydrochloride 1:1000 N.N.R.

CHEPLIN'S solution of this powerful vasoconstrictor, hemostatic and circulatory stimulant is adjusted to a definite standard strength and is physiologically assayed by measuring the effect on blood pressure.

EPINEPHRINE HYDROCHLORIDE may be administered by hypodermic, inhalation or topical application, affording rapid relief of asthmatic symptoms, urticaria, angioneurotic edema, reactions following injections of biologicals, shock or collapse, and prompt control of certain types of hemorrhage. When used in conjunction with topical, nerve block or infiltration anesthesias, it produces a bloodless operative field and retards absorption of the anesthetic—thus prolonging the period of anesthesia. Literature on Request.

ACCEPTED AMERICAN MEDICAL ASSN

EPINEPHRINE HYDROCHLORIDE is packaged as 1:1000 in:

1 cc. ampules.
10 cc. rubber-stoppered vials.
30 cc. rubber-stoppered vials.
30 & 480 cc. bottles for topical applications.

"ACCEPTED STANDARDS AT AN ACCEPTABLE COST"

CHEPLIN BIOLOGICAL LABORATORIES, INC.
(Unit of Bristol-Myers Company)
Syracuse, New York

to correct what is, in our opinion, a perfectly ridiculous situation. Goodness knows, there should be no breach between madicine and dentistry. That can not be tolerated not only for the good of the public but for the good of the two professions.

The dentist is an expert in his field; the physician in his. Each should recognize the ability and professional status of the other. They should work together closely as consultants. Neither should presume to give advice or perform services which infringe upon the other's field.

Improvement in relations between the two professions should be a "must" item on the schedules of all medical and dental societies. We suggest that this matter be given prompt attention by all county medical societies. Joint meetings and discussions of scientific, as well as economic questions, are recommended as one step toward smoothing out the relationships between individual dentists and physicians if they are not what they should be.

YES, DOCTOR, "THE CHIPS ARE DOWN" TO BE CALLED ON NOV. 7

In the past several issues, *The Journal* has been urging Ohio medical officers to obtain absent voter's ballots and to be sure to participate in the vital November 7 General Election. Procedure for obtaining ballots was outlined in detail, especially that provision which permits relatives of service men to file an application for a ballot on behalf of the man in the service with the county board of elections.

What about the physicians back home?

Specifically: What about you, Doctor?

Are you registered so that you will be eligible to vote? If there is a re-registration in your city this year, have you registered and qualified? If not, don't overlook this important matter.

Are your friends and neighbors registered?

If you plan to be away from home on November 7, have you arranged to vote by absent voter's ballot?

Don't you think it is vital that every citizen—specifically, every physician—should be qualified to vote and should vote on November 7?

Other groups think this is important. Also, they are "organizing" their votes. They have expressed their views as to how they would like to have their members and supporters vote.

For example, read the following text of a political advertisement published in a Columbus newspaper, over the signature of "The National Citizens Political Action Committee", a group supported by the C.I.O.:

THIS IS YOUR FIGHT

"This is crisis time, Americans! You can't shrug off this November's elections and say What's the difference?. This is 1944. The chips are down. Your job, your future, your very freedom—the kind of world your kids will grow up in—will be decided less than four months from now—by—YOU!

"The Old Guard has patched together the Republican platform—the same old privileges for the few, and no hope for the rest of us. The Old Guard has picked its candidates—the same old stooges for Hooverism and the Old Deal!

"Are you going to sit by and watch all your hard-won gains of the past twelve years vanish on Election Day? Do you want another sabotaged peace—another and more devastating war?

"There's a tough campaign ahead. Our opponents are more determined than ever. They're raising huge campaign funds—millions on millions—to elect their candidates.

"It's going to take working, fighting, organizing. But we can do it, if you'll help. The successes of the CIO Political Action Committee have demonstrated that the job can be done if our side is organized. But under Federal law some election campaign activities must be financed by contributions from individuals and not from union funds. CIO members are making their contributions. The National Citizens Political Action Comittee has been organized to give you an opportunity to get into this fight. We invite all like-minded Americans—farmers, workers, business and professional men and women—to join with us to do the job that can and must be done.

"This new committee needs funds—funds to register and get out the vote on Election Day. Funds to present the cause of progress, and jobs for all, to the people. Funds to help candidates, irrespective of party, who stand for total victory, a just and durable peace, and full employment.

"This is your fight Americans! We can't win it without you. Send a check or money order today . . . "

Yes, Doctor, "the chips are down". You are familiar with the issues. **It is the duty of every physician to qualify to vote; vote—and vote intelligently—on November 7.**

SERVICES OF CLEVELAND MUSEUM SHOULD BE UTILIZED

The Cleveland Health Museum was given a well-deserved boost in the August 12 issue of *The Journal of the American Medical Association.*

It is suggested that medical societies, health organizations and others desiring assistance in health education projects requiring displays and exhibits make use of the facilities of the Cleveland Health Museum. Ohio certainly should take advantage of the assistance which this nationally recognized organization is equipped and willing to give in the field of public information on medical and health questions.

In the first 31 weeks of 1944, the United States had more cases of infantile paralysis reported than at any comparable time shown on the records in 28 years.

Figures from the U. S. Public Health Service, showing state reports through August 5, revealed a total of 3,992 cases.

All alike?

RABBIT EYE TESTS* TELL A DIFFERENT STORY!

Edema 0.8 (from PHILIP MORRIS Cigarettes) vs. Edema 2.7 (from *ordinary* cigarettes) clearly reveals the wide difference in irritation caused by different cigarettes.

Equally conclusive are clinical tests.** They have proved over and over again that PHILIP MORRIS Cigarettes are definitely and measurably less irritating to the nose and throat.

Doctor, may we urge you to make your own tests . . . on smokers whose throats are irritated from smoking . . . and *see* PHILIP MORRIS' superiority for yourself!



0.8 . . . *Average edema upon instillation of smoke solution from* **PHILIP MORRIS CIGARETTES.**



2.7 . . . *Average edema upon instillation of smoke solution from* **ORDINARY CIGARETTES.**

PHILIP MORRIS

Philip Morris & Company, Ltd., Inc., 119 Fifth Avenue, New York

*Proc. Soc. Exp. Bio. and Med., 1934, 32, 241-245.
**Laryngoscope, 1935, XLV, No. 2, 149-154.

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—Country Doctor Pipe Mixture. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

In Memoriam

Robert Lenox Barnes, M.D., Columbus; Ohio State University College of Medicine, 1910; aged 58; member of the Ohio State Medical Association and Fellow of the American Medical Association; died August 2. Dr. Barnes retired because of ill health in June, 1943, after having practiced in Columbus for over 30 years. He was a former chief of staff of Mt. Carmel Hospital. Dr. Barnes was a member of the Masonic Order, Nu Sigma Nu, and the Methodist Church. His widow and a sister survive.

Webster A. Becher, M.D., North Industry; University of Wooster, Medical Department, 1902; aged 76; member of the Ohio State Medical Association and the American Medical Association; died August 1. The death of Dr. Becher ended a total of 95 years of medical service to North Industry and vicinity by the Becher family. His father, the late Dr. H. W. Becher, practiced there for more than 50 years. A son survives.

William J. Blackburn, M.D., Dayton; Pulte Medical College, Cincinnati, 1900; University of Michigan Homeopathic Medical School, Ann Arbor, 1915; aged 76; member of the Ohio State Medical Association and Fellow of the American Medical Association; member of the American Academy of Opthalmology and Otolaryngology and Fellow of the American College of Surgeons; died July 16. Dr. Blackburn was a member of the staff of Miami Valley Hospital for 25 years, a member of the board of trustees for 21 years, and a lecturer at the hospital's school of nursing. Prior to beginning his medical education, Dr. Blackburn was superintendent of the Lockington public schools from 1893 to 1896. Active in community and professional affairs, Dr. Blackburn was a past-president of the Ohio State Homeopathic Society, Southern Homeopathic Society, Dayton Opthalmological and Laryngologic Society; Exchange Club, Noontide and Triangle Clubs. In Masonic circles he was a past master of the Conservancy Blue Lodge and a past potentate of Antioch Shrine. Dr. Blackburn also was actively associated with the Dayton Y.M.C.A., Community Chest, Montgomery County Tuberculosis Association and other organizations. His widow and a daughter survive.

Aaron Fenton Burson, M.D., Oakwood; Eclectic Medical College, Cincinnati, 1910; aged 59; member of the Ohio State Medical Association and the American Medical Association; died August 8, in an automobile collision. Active in the Paulding County Medical Society of which he was president and former secretary-treasurer, Dr. Burson had practiced there for over 30 years. Surviving are his widow, three sons, two sisters and a brother.

Edwin Myron Case, M.D., Canton; University of Nebraska College of Medicine, Omaha, 1933; aged 44; member of the Ohio State Medical Association and Fellow of the American Medical Association; died July 22. Dr. Case had practiced in Canton for three years. Previously he was located in Nebraska and Wisconsin. Surviving

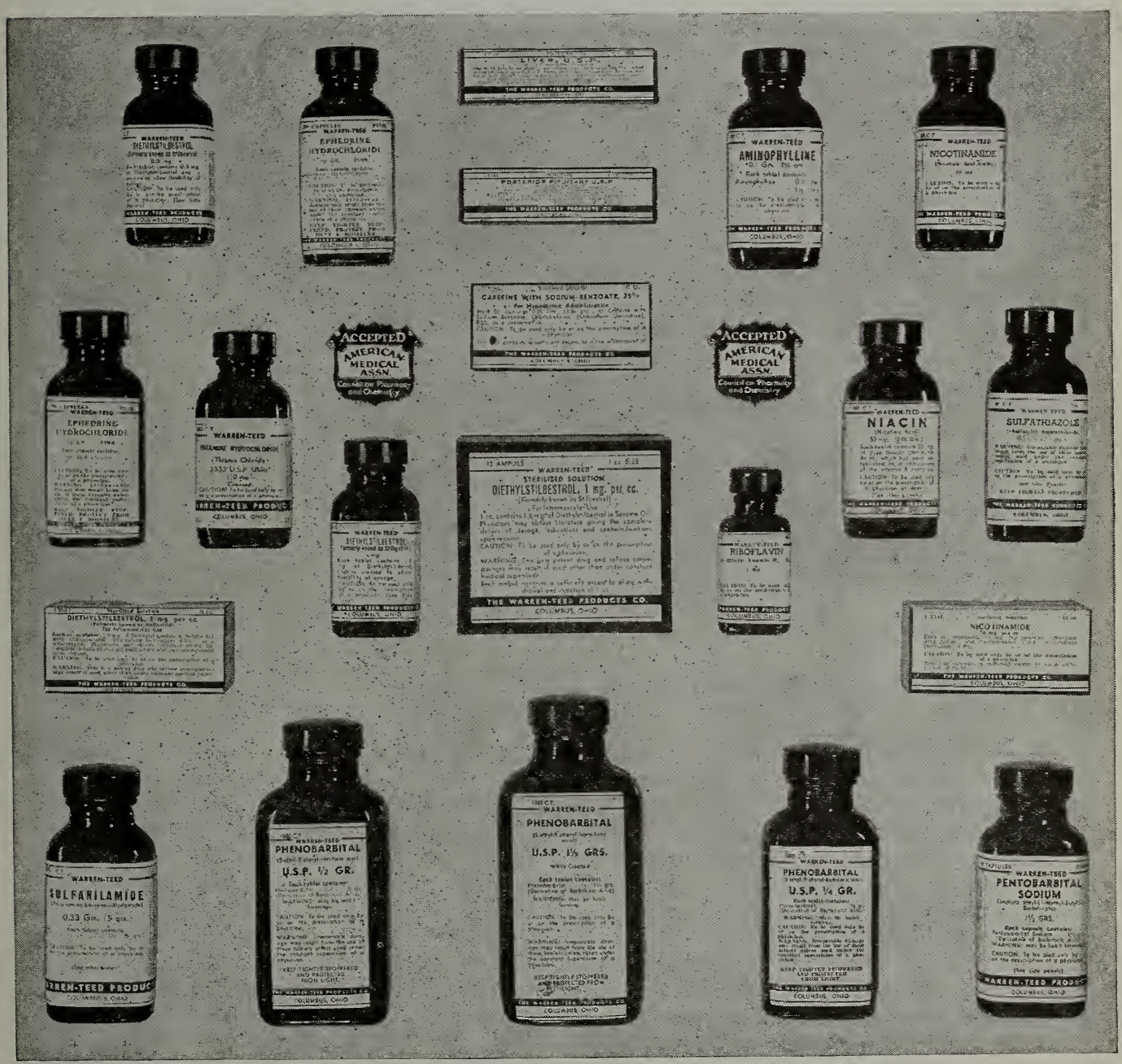
KILLED IN ACTION

Leo Edwin Apanasewicz, M.D., Cleveland; St. Louis University School of Medicine, 1941; aged 29; Captain in the Medical Corps of the Army of the United States; died June 15, in an army hospital in England, of wounds received a half hour after landing in Normandy on D-Day, June 6. Dr. Apanasewicz had previously served in the North African and Italian campaigns. He was buried with full military honors in an American cemetery near London. Dr. Apanasewicz was commissioned as a medical officer in July, 1942, upon the completion of his internship at St. John's Hospital, Cleveland. His father and three sisters survive.

☆ ☆ ☆

Warren Griffith Parish, M.D., Cleveland; University of Pennsylvania School of Medicine, Philadelphia, 1933; aged 37; member of the Ohio State Medical Association and Fellow of the American Medical Association, died July 29, of wounds received three days earlier while in action on Guam. A former intern at the Cleveland Clinic and resident at Lakewood Hospital, Dr. Parish was commissioned in the Navy in August, 1942, and held the rank of lieutenant. He had been in the South Pacific since February-, 1943, bting assigned to a Marine division which served in New Zealand and Guadacanal. During the invesion of Guam he suffered abdominal wounds when a Jap raiding party almost wiped out his field hospital unit. Dr. Parish died on a hospital ship off Guam. Surviving are his widow, a daughter, a son, his parents and a brother.

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are his widow, a daughter, a son, his mother and a brother.

Homer Harvey Ewing, M.D., Willard; Cleveland Pulte Medical College, 1898; aged 76; member of the Ohio State Medical Association and the American Medical Association; died July 20. A former president of the Huron County Medical Society, Dr. Ewing practiced there for over 40 years. Previously he had been located in Lima for a short time. Dr. Ewing was active in many civic organizations, including the Rotary Club, Commercial Club and the Huron County Public Health Association. He was a member of the Presbyterian Church for 40 years, and a trustee and elder for many years. Surviving are his widow, a son, a brother and four sisters.

Charles A. McNeil, M.D., Toledo; University of Michigan Medical School, Ann Arbor, 1923; aged 51; member of the Ohio State Medical Association and Fellow of the American Medical Association; died July 27, at the Station Hospital, Great Lakes, Ill. A Lieut. Comdr. in the Medical Corps of the U. S. Navy (R), Dr. McNeil was senior medical officer of the Naval Officer Procurement Service in St. Louis. He was a veteran of World War I, and returned to the service in June, 1942. Dr. McNeil practiced in Toledo for nearly 20 years. He was a member of the American Legion, 40 and 8, Knights of Columbus and other local organizations. His widow and a sister survive.

Bernard William Meyer, M.D., Columbus; Ohio Medical University, Columbus, 1897; aged 80; died August 11. A practicing physician in Columbus for many years, Dr. Meyer previously was located in Cynthiana, Ky., and West Jefferson. His widow and two sisters survive.

Andrews Rogers, M.D., Columbus; Columbia University College of Physicians and Surgeons, 1901; aged 71; former member of the Ohio State Medical Association and the American Medical Association; Diplomate of the American Board of Obstetrics and Gynecology; died August 6. Emeritus professor of obstetrics at Ohio State University College of Medicine, Dr. Rogers retired a year ago after over 40 years on the faculty of that institution. For many years he was a member of Publication Committee of *The Ohio State Medical Journal*, and had been its chairman. His widow and a brother survive.

Charles Hurd Ross, M.D., Alliance; Columbus Medical College, 1892; aged 77; died August 11. Dr. Ross practiced in Alliance for 37 years. He previously was located at Dell Roy. Surviving are his widow, a daughter and a son.

Frank Lyon Salisbury, M.D., Russellville; Ohio State University College of Medicine, 1917; aged 51; member of the Ohio State Medical Association and Fellow of the American Medical Association; died August 1. A native of Russellville, Dr. Salisbury was a 1st Lieut. in the Medical Corps of the U. S. Army during World War I, and later was in the service of the Veterans' Administration. Following several years of practice in Cleveland, he located in Russellville about ten years ago. Dr. Salisbury was a delegate from the Brown County Medical Society to the Ohio State Medical Association in 1942. He was a past master of the local Masonic Lodge, a member of the American Legion and the Presbyterian Church. A brother and a sister survive.

Frank Scheerer, M.D., Los Angeles, Calif.; Miami Medical College, Cincinnati, 1896; aged 78; former member of the Ohio State Medical Association and the American Medical Association; died July 11. Dr. Scheerer retired in 1940 after having practiced in Cincinnati for over 40 years. Two daughters and a son survive.

Isaac Grafton Sieber, Jr., M. D., Cleveland; Temple University School of Medicine, Philadelphia; 1932; aged 40; member of the Ohio State Medical Association and Fellow of the American Medical Association; died August 5. Dr. Sieber had been with the U.S. Public Health Service, attached to the Coast Guard at Boston, for the past two years. Previously he had practiced in Cleveland for eight years, and was a member of the staffs of St. Alexis, Glenville and Booth Memorial hospitals. His widow, three children and his father survive.

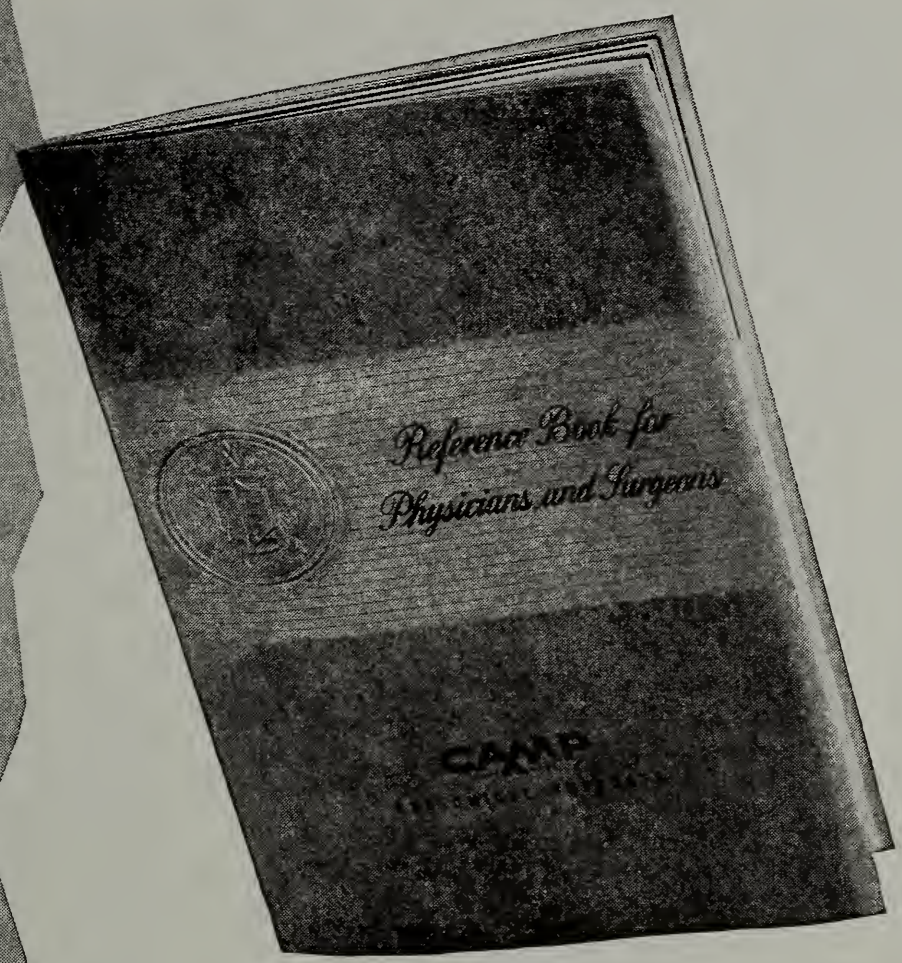
Charles Ira Stephen, M.D., Ansonia; Starling Medical College, Columbus, 1897; aged 71; member of the Ohio State Medical Association and Fellow of the American Medical Association; died July 12. Widely known in medical circles throughout the state, Dr. Stephen practiced in Darke County for over 40 years. He represented the Darke County Medical Society in the House of Delegates of the Ohio State Medical Association continuously since 1925. Also he had been a member of the Committee on Public Health Education of the State Association. Dr. Stephen was a member of the board of directors of Wayne Hospital, Greenville, and had been a member of the Darke County Board of Health since 1922. He was an active member of the Masonic Lodge and the Christian Church. Surviving are his widow and three daughters.

Edmund Arthur Weeks, M.D., Akron; Western Reserve University School of Medicine, 1900; aged 69; member of the Ohio State Medical Association and Fellow of the American Medical Association; died August 2. A practicing physician in Akron for over 40 years, Dr. Weeks was a former president of the Summit County Medical Society and a former chief of staff of People's and Children's hospitals. His widow, a daughter and a sister survive.

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Health and Human Resources in Rural Ohio

A. R. MANGUS, COLUMBUS, OHIO
Department of Rural Economics and Rural Sociology, Ohio State University

Installment No. 1

DURING the past 40 years very great advances have been made in knowledge, skills and facilities for the protection of human health, and for alleviating many of the ills and disabilities to which human beings are exposed. Application of this new knowledge and of new techniques has produced outstanding results. The average length of life has been increased by about 15 years since 1900, and several previously dreaded diseases, such as smallpox and typhoid, have been brought under control.

In spite of the many advances in protecting human life and welfare, there is still a vast amount of human loss and much unnecessary wastage of human resources on farms, in towns and in cities. Such wastage is reflected in premature deaths, in illness, disabilities and impairments, and in personal and social maladjustments of all degrees of seriousness.

In rural Ohio, for example, about one in each 10 deaths that occur involves a person under 15 years old, and one in each five deaths occurs to a person less than 45 years old. For each annual death to persons in those early and middle years of life, there are probably 200 or more nonfatal illnesses and accidents. Losses of human capacities for happiness and social usefulness are also reflected in the impairments shown in the results of Selective Service physical examinations. Since 1940 when Selective Service was initiated, from one-third to one-half of all registrants examined have been rejected because of physical and mental defects.

Confronted with an apparent discrepancy between knowledge of means of conserving human health possessed by specialists on the one hand and a vast amount of physical and mental ill health on the other, this report aims at answers to six major questions: (1) What is good health? (2) What is the present condition of human health in rural areas of Ohio, as indicated by deaths, illness, and mental breakdown? (3) What are some of the basic population trends and conditions which affect the outlook for rural health? (4) What are the specific causes of death and of illness of persons at different ages? (5) How are health services and facilities distributed in Ohio with respect to rural needs? (6) What social action is needed for the conservation of rural health?

The data for this report have been assembled from many different sources, but the focus of attention in the analyses is upon the rural health situation in Ohio. In the search for pertinent information both official statistical reports and reports of special studies have been used. Some use is also made of a firsthand study of the health situation among low income families that received service under Farm Security Administration Medical Care Plans in Ohio counties.

It has been recognized for some time that continued survival of population depends upon the conservation of natural resources. It is further agreed that the level of survival, including the happiness and social usefulness of individuals depends upon the conservation of fundamental human resources among which health is number one in importance. There has been a tendency both among farm and city people to look upon health as a negative quality, that is as mere absence of bodily aches and pains or specific diseases. Now, however, it is coming to be

EDITOR'S NOTE: It is the obligation and responsibility of the medical profession to cooperate with other reliable groups in efforts to conserve and improve the health of those residing in the rural communities of Ohio where health conservation programs have not been operated on as an extensive a scale as in urban areas of the state.

The prelude to bringing about improvements in health programs in rural sections of Ohio entails the assembling, review and interpretation of data on existing conditions. An important contribution to this phase of the question has been made by A. R. Mangus, Department of Rural Economics and Rural Sociology, Ohio State University. In a study, just completed, Mr. Mangus has presented some vital data on health conditions among the rural population of Ohio and has made some pertinent suggestions regarding a rural health policy of this state.

Believing that the physicians of Ohio should have access to information of this kind so that they will be better prepared to assist in constructive planning and action, The Ohio State Medical Journal has obtained the permission of Mr. Mangus to reproduce his most recent study, "Health and Human Resources in Rural Ohio" in installments. This is the first of the series of articles; others will appear in subsequent issues of The Journal.

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The chances are 48/100 her skin, from a cosmetic viewpoint, is dry; 25/100 it is normal; 9/100 it is a combination type, i.e. dry cheeks with so-called oily inner circle—nose, chin, forehead; and 18/100 it is oily. The chances are 45/100 her skin is tender; 34/100 it is easily irritated.

The chances are 37/100 her eyes are blue; 33/100 they are brown; 15/100 they are hazel; 5/100 they are green; and 10/100 they are grey.

The chances are 54/100 her hair is some shade of brown, ranging from light to dark; 20/100 it is blond; 7/100 it is red; 9/100 it is black; and 10/100 it is grey or white. The chances are 32/100 her hair, from a cosmetic viewpoint, is dry; 45/100 it is normal; and 23/100 it is oily.

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thought of as a positive state of personal and social living. It is not something that the individual does or does not possess, but which one possesses in various grades and degrees.

Good health is then much more than mere absence of sickness, and it includes also absence of continued mental conflicts and of emotional disturbances. From the point of view of this discussion, good health is the positive ability of a person to mobilize proper amounts of energy and to direct his energies to socially useful and personally satisfying ends. It is measured in the individual by the efficiency with which he functions in his family, in his work, and in his community.

Ill health on the other hand appears not only in bodily injuries, disabilities and impairments, but also in disturbed mental functions as in nervousness and insanity. Ill health is also reflected in disturbed social functions as in divorce, delinquency and crime.

It is unfortunate that so far very few studies of rural health have been made; consequently, the incidence of good health in the rural population is an unknown quantity. For the most part available statistics serve only to indicate the prevalence of extreme types of ill health. This report is concerned mainly with statistics of that type.

PRESENT CONDITIONS OF RURAL HEALTH

Present conditions of rural health in Ohio are indicated by certain indexes. Among these indicators are births and deaths, illness and impairments, and mental breakdown.

Deaths. The year 1940 was the first census year for which births and deaths were reported by place of residence rather than by place of occurrence. Hence, for the first time it becomes possible to accurately determine differential birth and death rates between rural and urban areas. During that year a total of 39,069 babies were born to mothers living on farms and in small villages with less than 2,500 population in Ohio. During that same year a total of 25,997 rural residents died. Hence, for rural Ohio there was in 1940 an excess of 13,072 births over deaths. In the absence of migration this annual excess of births would be sufficient to increase the rural population by more than 5 per cent within a 10 year period.

For the white population of Ohio the general death rate per 1,000 population was 11.2 in 1940. It is of considerable interest that the death rate was highest among rural residents and among residents of small towns and cities of less than 10,000 population. It was lowest in the medium-sized cities with from 10,000 to 100,000 inhabitants and was somewhat higher in the larger urban centers (Table 1).

Table 1. Specific Resident Death Rates per 1,000 Population by Age and Residence, White Population, Ohio 1940

Age	Total	Rural	Urban population size groups		
			2,500–10,000	10,000–100,000	100,000 and over
All ages	11.2	11.5	11.8	10.5	11.2
Under 1 year	47.1	48.9	50.4	46.1	44.3
1- 4 years	2.3	2.5	2.8	2.1	2.0
5-14 "	1.0	1.0	1.0	0.9	0.9
15-24 "	1.6	1.7	1.7	1.4	1.5
25-34 "	2.4	2.5	2.6	2.2	2.5
35-44 "	4.4	4.1	4.1	3.9	4.9
45-54 "	9.4	8.1	8.6	8.8	10.8
55-64 "	20.9	18.3	19.7	19.9	24.3
65-74 "	47.7	42.9	44.7	47.4	54.6
75-84 "	117.9	118.0	113.9	112.3	123.0
85 years & over	248.5	254.3	264.3	251.5	231.1

Source: United States Bureau of the Census, Vital Statistics Rates in the United States, 1900-1940. Table 11, p. 205.

The higher general death rate in rural areas and in the small towns and cities of Ohio can not be accounted for entirely by differences in the age composition of the respective populations. Age-specific death rates were considerably higher among rural infants and children, and to some extent among rural youths 15-24 years of age, than among comparable age groups in the larger cities. The incidence of deaths among rural residents was considerably below the state average for the years 35-74, but was above the state average for the very aged people (Table 1).

Births. During the year 1940 a total of 39,069 births occurred to mothers living in rural-farm and in rural-nonfarm homes in Ohio. That number comprised 34.1 per cent of all the 114,663 births to Ohio residents during that year.

The major factor affecting maternal and child health is the fact that more rural births occur in the home than in the hospital. In 1940 it is reported that 79 per cent of all births to mothers living in cities of 10,000 and over occurred in hospitals. During that same year only 40.8 per cent of the births to mothers who lived outside of cities 10,000 and over occurred in hospitals.[1] It is evident that an even smaller proportion of the babies borne by rural-farm and rural-nonfarm mothers was born in hospitals. The reports show that of the 39,069 births to these rural mothers 27,417, or 70.2 per cent, actually occurred in rural areas. Since there are very few hospital beds outside centers of 2,500 or more population, it may be assumed that practically all of these births occurred outside of hospitals. Moreover, it is probable that some of the rural mothers who were confined away from their usual place of residence were not hospitalized. It may be said then that while more than three-fourths of all urban babies are born in hospitals less than one-third of all rural babies have that advantageous start in life. The

[1]United States Bureau of the Census, Vital Statistics of the United States, 1940. Part II, Table T, p. 15.



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result is reflected in the much higher infant death rate in rural than in urban areas.

While maternity and child health services and facilities are much more meager in the country than in cities, refined birth rates are nevertheless much higher in the country. The crude birth rate for Ohio in 1940, expressed in terms of number of births per 1,000 population, was 16.6 and was only slightly higher for rural than urban residents. The similarity between the crude birth rate in the country and in the city was, however, more a reflection of differences in the age structure of the two populations than of similarities in actual fertility of rural and urban women. Differences in fertility or birth performance are more accurately measured by relating births to women of child-bearing ages rather than to total population.

Most births occur to women between the ages of 15-44 though a few births occur to women above and below those age limits. When birth rates were expressed in terms of numbers of births per 1,000 females 15-44 years old, they were found to be highest among rural women and lowest among women living in the largest cities (Table 2).

Table 2. Specific Resident Birth Rates per 1,000 Women by Age of Mother, and Population Size Groups, White Population, Ohio 1940

Population size groups	Age of Mother						
	15–44 years[1]	15–19 years	20–24 years	25-29 years	30–34 years	35–39 years	40-44 years
TOTAL	69.1	38.5	120.4	115.3	74.5	37.9	12.2
Cities of 100,000 or more	62.2	31.3	107.6	107.2	67.4	30.2	8.8
Cities of 25,000–100,000	63.6	39.3	109.0	108.9	67.7	31.2	8.0
Cities of 10,000–25,000	65.7	36.4	112.3	112.3	73.2	30.8	11.1
Cities of 2,500–10,000	69.4	42.0	120.5	118.4	70.9	38.3	11.1
Rural	81.3	44.6	145.4	129.5	88.8	52.5	19.4

Source: U. S. Bureau of the Census, Vital Statistics Rates in the United States 1900-1940, Table 51, p. 693.

1. Includes some births to mothers under 15 and over 45 years old.

The average number of births per 1,000 white women in the child-bearing ages was 69-1 in 1940. In the large cities, however, there were only 62.2 births per 1,000 women. This birth rate increased with each smaller population size group and reached a peak of 81.3 births per 1,000 rural women. In other words the refined birth rate was nearly one-third higher in rural areas than in the large cities. The age interval 20-24 years is the most fertile period in the lives of women in our society. In 1940 rural women in that age interval had 38 more babies per 1,000 than the urban women of that age who lived in the largest cities. The age-specific birth rate for these young women was 35 per cent higher in rural areas than in the big cities. Smaller-sized cities were intermediate with respect to age-specific birth rates. The differential age-specific birth rate among population size groups was similar for each other age interval of women in the child-bearing period (Table 2).

Illness and Other Disabilities. It is unfortunate that there is no official reporting and no published record of the prevalence and incidence of illness in Ohio. In the absence of official statistics of illness, it is necessary to rely on estimates from special sickness surveys or on evidences pertaining to certain age groups as in case of the draft rejections.

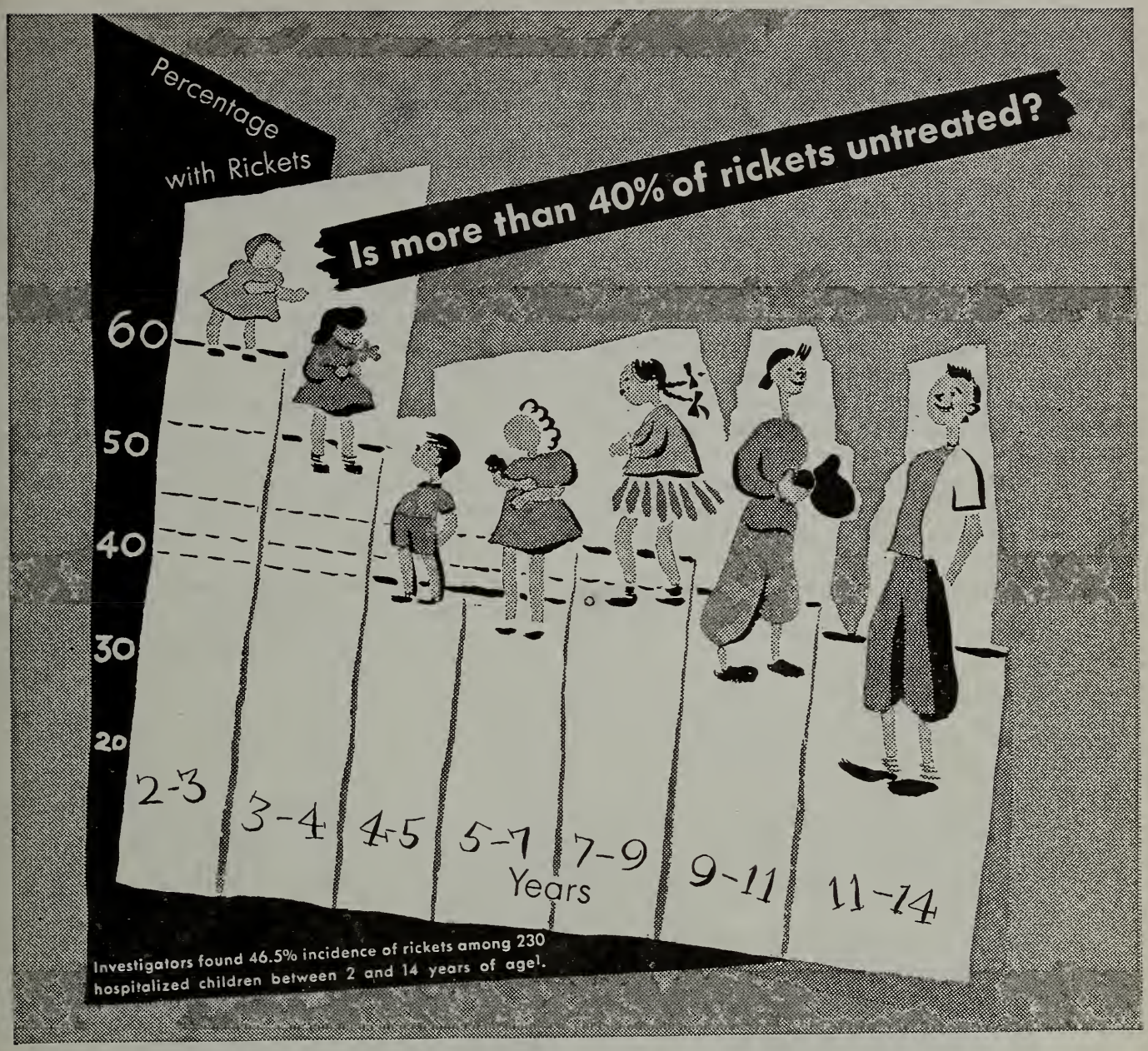
The best estimates of the incidence of illness and disability may be derived from two extensive national surveys. The first of these surveys was made by the Committee on the Costs of Medical Care during the period 1928 to 1931. The second was a more recent and a more extensive survey of illness made by the United States Public Health Service in 1935-1936 and known as the National Health Survey.

The data collected by the Committee on the Costs of Medical Care covered 8,758 white families, both rural and urban, in 130 localities scattered among 18 states. A major finding of that survey was that during a consecutive 12 months' period 52 per cent of all persons were sick one or more times with an illness sufficiently serious to be reported. The annual rate was 823 illnesses per 1,000 persons observed. The rate of disabling illnesses, that is which caused the person to lose one or more days from his usual work, school or other activities, was 492 per 1,000. The rate for bed cases was 414 per 1,000 persons.[2]

If we assume that these illness rates applied in rural Ohio in 1940, then rural people in the state experienced 1,900,000 cases of illness during that year, of which 59.8 per cent were disabling, and 50.3 per cent were sufficiently disabling to confine the patient to his bed.

The study of illness made by the National Health Survey is not comparable with the earlier study. The figures in this later study relate to illnesses which had disabled the person for at least seven consecutive days during the 12 months' period preceding the survey. On the basis of the findings from the National Health Survey, it was estimated that 7,000,000 people

2. Collins, Selwyn D., "The Incidences and Causes of Illness at Specific Ages", The Milbank Memorial Fund Quarterly, Vol. 13, No. 4, pp. 320-338, Oct. 1935.



It used to be thought that rickets is prevalent only in the first two years of life. This was when the roentgenological and clinical manifestations were accepted as the criteria for diagnosis. Recent studies suggest that perhaps as the result of this impression, as much as 40% of rickets has gone untreated.[1]

Microscopic examination of the long bones of children between the ages of 2 and 14 who died from various causes showed a startlingly high percentage of cases of rickets in older children. The highest incidence was found during the third year (57%). This suggests the need of continuing vitamin D supplementation beyond infancy. Evidently, as long as growth persists, and at least through the fourteenth year, administration of vitamin D should be made routine; because even in children who appear healthy, histologic bone studies show that disturbances in calcium-phosphate metabolism are fairly common.

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1. Follis, R. H.; Jackson, D.; Eliot, M. M., and Park, E. A.: Am. Jrl. Dis. Child. 66:1 (July) 1943. Note: A reprint of this paper is being mailed to all physicians. Additional copies are available upon request.

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in the United States are permanently or temporarily disabled each day. A little less than 50 per cent of these are incapacitated for more than six months. Of these disabled for more than a half year about three-fifths are physically disabled while two-fifths suffer primarily from mental disability.[3]

The incidence of disabling illness lasting for a week or longer was highest among aged people past 65 years old and among children under 15. It was lowest among youths 15-24 years old. Even among this youth group, however, there occurred 131 disabling illnesses per 1,000 persons per year. The illness rate was 214 per 1,000 for children under 15, and 279 per 1,000 for old people past 65. For persons in the middle years, 25-64, the illness rate was 153 per 1,000.

The disabling illness rate varied greatly by income levels. For example, there were 54 more illnesses per 1,000 among persons whose family income was less than $1,000 than among persons with family income of $1,500 or more. Nearly 18 per cent of all persons in the survey suffered from chronic diseases or impairments. The rate of chronic disability ranged from 3 per cent for children under five years of age to more than half for all persons 65 and over.[4]

The main causes of disability among persons included in the National Health Survey were pneumonia, tonsillitis, and other respiratory diseases, communicable diseases of childhood, maternity, confinements, diseases of the digestive system, accidents, cardiovascular and kidney diseases, and nervous and mental disorders.

The incidence of illnesses among low income farm families in Ohio is indicated by a current study of FSA Medical Care Programs in five southern Ohio counties. For all ages included in the study there were during the period 1940-1943, 2,300 doctors' calls annually per 1,000 persons. The call rate was lowest for children 5-14 years old, these children having a doctors' call rate of 996 per 1,000. The call rate for children under five years of age was 1,899 per 1,000. The rate was higher for youths 15-24, 1,972 calls per 1,000, and rose steadily to 3,844 per persons 45 years old and over.

Mental Breakdown. Many of the crucial health problems of today are due to the high incidence of mental, emotional, and social maladjustments. Among persons suffering from mental illness only the most severe cases are admitted to mental hospitals. Yet in 1940 the resident population in hospitals for mental diseases in Ohio amounted to 21,905.[5] This number included patients in state hospitals for mental disease, in veterans' hospitals, in county and city hospitals, in private mental hospitals, and in psychiatric wards of general hospitals. This resident population in mental disease hospitals amounted to 411.1 of each 100,000 people in Ohio.

There is no information available as to the number of rural people who are included among mental patients in hospitals. Statistics on county of residence of persons admitted to hospitals during 1940 indicated that a large proportion of mental patients come from rural areas. During that year a total of 4,413 persons were admitted to Ohio state hospitals for mental diseases, the admission rate being 82.8 per 100,000 population for the state as a whole. The rate of admission was highest for the 13 predominantly rural counties in the northern and western sections of Ohio. The admission rate was lowest for those counties comprising most of the southeastern part of the state **(Table 3).**

Only the most severe cases for mental disorder are hospitalized, and many grave cases eligible for hospitalization remain outside either because their friends and relatives prefer to care for them or due to limitation of institutional facilities. The incidence of milder cases of nervous or emotional disturbances and behavior disorders is very great. This is indicated by statistics which show that in some rural areas of Ohio about 15 per cent of all draft rejectees are rejected because of mental disorders.

Table 3. Admissions to State Hospitals for Mental Disease and Admission Rates per 100,000 Population 15 years and over by County Size Groups

County size group	Population range of county	Population 15 years old and over	Admissions	Admission rate per 100,000 pop.
All counties		5,328,752	4,413	82.8
Large counties	200,000 & over	2,902,136	2,619	90.2
Medium large counties	50,000–200,000	1,135,143	852	75.1
Medium small	25,000–50,000	906,862	639	70.5
Southeastern area	–	240,905	146	60.6
Other counties	–	665,957	493	74.0
Small counties	25,000 & less	384,611	303	78.8
Southeastern area	–	177,681	110	61.9
Other counties	–	206,930	193	93.3

Source: Sixteenth Census of the United States, 1940 "Population", Second Series, Table 7, p. 13, and Annual Report of the Secretary of State (Ohio) for the year ending December 31, 1940, pp. 129-132.

(To Be Continued)

3. National Resources Planning Board, Human Conservation, March 1943. p. 17.

4. Britten, R. H., "The National Health Survey", U. S. Public Health Service, Public Health Reports, Vol. 55, Part I, pp. 444-470, March 15, 1940.

5. United States Bureau of the Census. Patients in the Mental Hospitals 1940, Table 3, p. 8.

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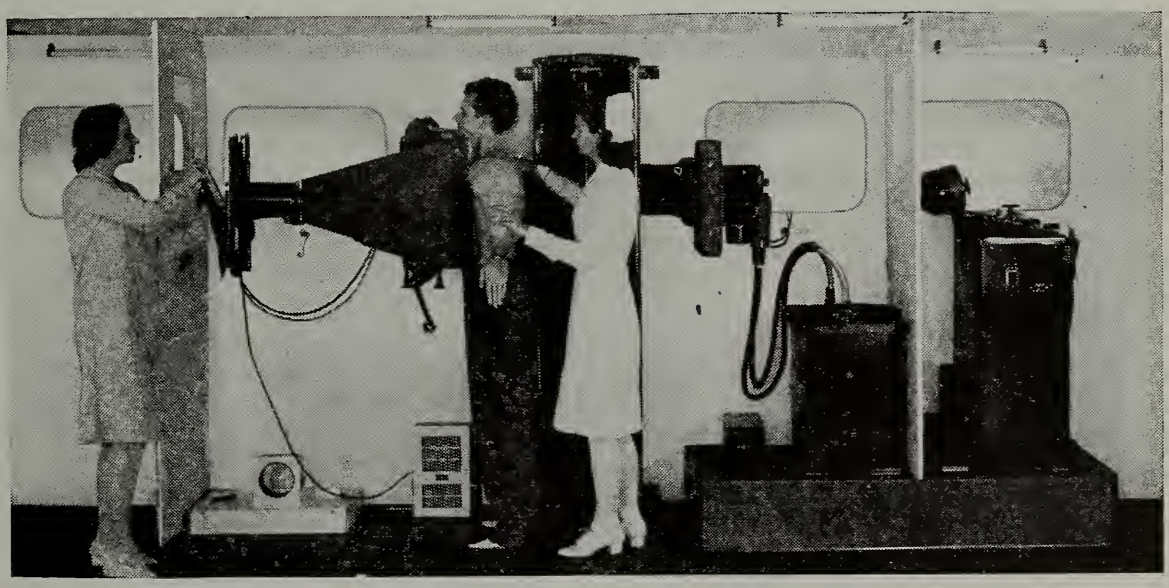
In light of statistics which point to a half-million cases of active tuberculosis in the United States, and 60,000 deaths annually from this disease, it is heartening to grasp the significance of the following statement by Surgeon General Thomas Parran, in a paper read before the A.M.A convention in Chicago:

"The mass case-finding program for the control of tuberculosis launched by the U. S. Public Health Service early in 1942 has demonstrated the value of the small-film x-ray.

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Postwar Problems in Medical Education Emphasized in A.M.A. Report on Schools, Faculties, Students, Etc.

IMPROVEMENT of curriculums in medical schools to prepare the student more adequately for the problems of today, the early release from the armed forces during the period of demobilization of physicians on medical school faculties so as to restore the quality of medical instruction to a higher level as soon as possible, and the provision of further education for discharged medical officers are the chief challenges facing medical education today, *The Journal of the American Medical Association* for August 19 points out. *The Journal* says:

"The medical schools and their faculties have met the challenge of wartime conditions creditably, teaching more students in less time than formerly in the face of greatly depleted numbers of instructors. The devotion of faculty members who carried on the increased work under adverse conditions is highly commendable. In the period of demobilization to come, special consideration should be given to the preferential early release of physicians on medical school faculties so as to restore the quality of medical instruction to a higher level as soon as possible.

COURSES FOR DISCHARGED OFFICERS

"The studies carried out by the Committee on Postwar Medical Service . . . indicate the magnitude of the problem of providing further education for discharged medical officers. There were requests for additional postwar training from 796 of 1,000 officers replying to a questionnaire. Nearly 34 per cent requested courses of less than six months' duration. Nearly 46 per cent desired further work in hospitals for six months to three or more years. Provision of the requisite additional educational opportunities will require the concerted efforts of internship and residency hospitals, medical schools, medical societies, specialty boards and others. We owe this service to those medical officers whose education was interrupted by the war.

"Numerous problems in undergraduate medical education also must be met. Wartime experiences in medical care for the armed forces and for civilians have accentuated the growing importance of certain expanding fields of medicine. Notable among these are neuro-psychiatry, public health, industrial health, physical medicine and tropical medicine. . . .

IMPROVED CURRICULUM

"More material cannot be added to the undergraduate curriculum unless other subject matter is withdrawn. At many points a reduction of the content of 'courses' not only would be possible but would improve the educational program. Vested interests of certain departments or faculty members, established by outworn tradition or the aggressive capturing of curricular time, must not be permitted to stand in the way of an improved curriculum which will more adequately prepare the student for the problems of today in medicine."

In the same issue of *The Journal* is the annual compilation of information on medical education in the United States and Canada, prepared by the Association's Council on Medical Education and Hospitals. Emphasizing the importance of the need for the early discharge from the armed forces at the end of the war of physicians on medical school faculties is the report that on July 1, 1944, the seventy-seven medical schools and schools of basic medical sciences in the United States had contributed a total of 5,828 of their faculty members to the armed forces. This is in excess of 10 per cent of the medical officers in the armed forces.

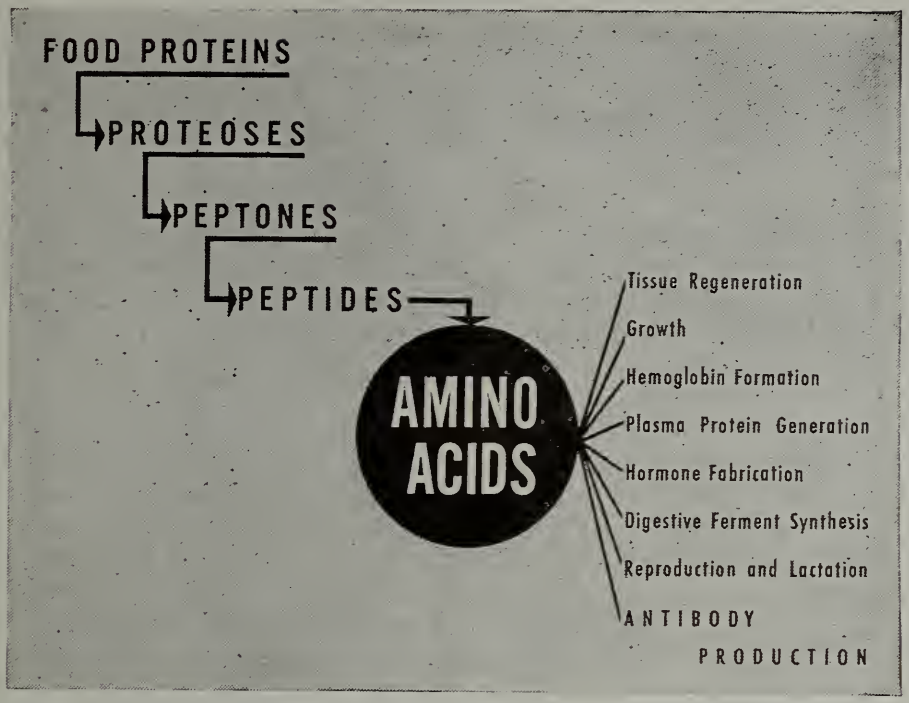
MORE GRADUATES

Discussing the status of students in medical schools, the report points out that between July 1, 1942, when the accelerated educational program was inaugurated in most schools, and June 30, 1944, there were 10,357 medical graduates. From July 1, 1944, to June 30, 1945, there will be approximately 9,844 graduates, making an estimated total of 20,201 graduates for the four-session three-year cycle. This rate of production of physicians exceeds that of any previous time in the history of the country. Between July 1, 1943, and June 30, 1944, there were 5,134 graduates. The four schools graduating the most students were Illinois, 161; Northwestern, 161; Jefferson, 133; and Harvard, 132. During the same time the nine medical schools of Canada graduated 523.

During the present academic session which for most schools runs from about January to September, 1944, there were 23,782 students enrolled in the schools of the United States and Canada. This is an increase of 253 over that of the preceding session. In the past three sessions enrollments have increased 2.7 per cent, 4.0 per cent and 1.1 per cent.

OHIO RANKS FOURTH

The seventy-seven approved schools in the United States are located in thirty-six states and the District of Columbia. Every state in the Union, including the District of Columbia, had eighteen or more students in these schools. The



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largest number of students from any one state was 2,881 from New York; next in order are Pennsylvania, 1,857; Illinois, 1,384; Ohio, 1,298; and California, 1,162. These five states supply a total of 8,582 students, or nearly a third of the registration of the eighty-seven approved schools in the United States and Canada.

Students in the first academic session commencing in 1943 in the United States and in Canada totaled 25,113 men and 1,379 women. Graduates from July 1, 1943, to June 30, 1944, in the United States and Canada numbered 5,390 men and 267 women. In the United States women students numbered 1,176 as compared with 22,352 men. For the academic session commencing with the first class entering in 1943, the percentage enrollment of women (5.0 per cent) was somewhat less than in the preceding year (5.1 per cent), and the percentage of graduates (4.7 per cent) was somewhat higher than in the preceding year (4.6 per cent).

SEE SHORTAGE OF STUDENTS

In this connection, the report emphasized a medical education problem to which attention has been called frequently in recent weeks in connection with the present policies of the National Selective Service regarding premedical and medical student deferments. Due to the curtailment of the Army Student Training Program, the medical schools of the country will have to select 75 per cent of their 1946 freshmen from civilians.

"This is manifestly impossible", the report says, "and it is probable that entering classes in 1946 will be approximately half filled unless the Enlisted Reserve Corps are reinstituted or Selective Service regulations changed."

The report estimates that, taking into consideration the reduced number of graduates that will ensue from this program, less the number of physicians who die each year, there will result an annual and cumulative deficit of 1,000 doctors a year. An unknown number of war casualties among medical officers will also reduce the supply of physicians.

CONTINUATION COURSES

"The necessity for continuation courses of study in the medical specialties has never been more urgent than at the present time", the report points out. "Physicians in civilian practice have been compelled to enlarge their field of activity and to refresh their knowledge of the intricacies of modern diagnosis and treatment. Physicians in military service and returning medical officers are also encountering problems. The demand for all means of instruction is greater than it has ever been. Medical educators and interested agencies throughout the country are attempting to assist physicians called on to assume new responsibilities by offering refresher courses or continuation courses and by the presentation of scientific papers or lectures on timely subjects. . . .

"The Council on Medical Education and Hospitals publishes semiannually advance information concerning graduate continuation courses for practicing physicians. These include courses in a wide variety of fields in clinical medicine and the basic sciences. The courses are for variable periods from a few days to several months. Some are concentrated full time courses and others are part time."

DISTRIBUTION OF PHYSICIANS

Discussing the maldistribution of physicians to urban and rural communities which has been accentuated by the war and the fact that several states are contemplating the formation of new medical schools "to provide doctors for rural communities", *The Journal* declares that such moves will not solve this problem. It says:

"Within the past year three schools have been added to the list of approved medical schools maintained by the Council on Medical Education and Hospitals.

"The Southwestern Medical School of the Southwestern Medical Foundation is located at Dallas, Texas. Dr. Tinsley Harrison is dean of the faculties.

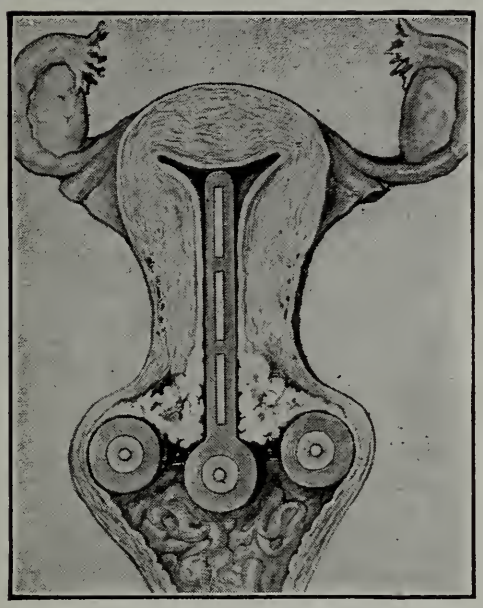
"The Bowman Gray School of Medicine has expanded from a school of the basic medical sciences to a four-year medical school, located at Winston-Salem, N.C. Dr. C. C. Carpenter continues as dean.

"Under the deanship of Dr. A. Cyril Callister, the University of Utah School of Medicine, at Salt Lake City, has also developed a four-year program.

"The University of Alabama has virtually completed arrangements for expansion to the four-year status, employing the facilities of the Hillman and Jefferson hospitals in Birmingham. It is anticipated that junior instruction will commence about July, 1945, under the direction of Dean Roy R. Kracke. Dr. Stuart Graves will continue as dean of the basic sciences.

"The Council on Medical Education and Hospitals is glad to encourage and assist well planned institutions in developing medical schools where the need exists; it must, however, discourage ill conceived ventures in medical education. New and more medical schools will not solve the problem of distribution of medical care. There is no assurance that more doctors will practice in rural communities if more doctors are produced. The rate of production of doctors and their adequate distribution are independent problems."

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The Physician's Bookshelf

Nutrition and Physical Fitness, by L. Jean Bogert, Ph.D. ($3.00. 4th Edition fully revised. *W. B. Saunders Co., Philadelphia).* Here is a book with which we physicians could well spend all our spare time for the next two or three months. It is a book we ought to lend to all of our intelligent, reading patients. For it teaches that our health and physical fitness depends upon the state of our nutrition; that the state of our nutrition depends primarily upon the quality of food; that the quality of food depends, in turn, upon the quality of the soil upon which it has been grown. Hence the emphasis upon the quality of protein, upon vitamins, and upon minerals.

Our citizens are coming to realize that we physicians are not trained in matters of health, or only indirectly so at best. Our training is based upon organic, and therefore irreversible, pathology. We are interested in sickness and disease—the very opposites of health. Our medicines may stop the ravages of disease or they may relieve the pain it produces. To promote health we must as citizens turn our attention to prevention. It takes a good state of nutrition and physical fitness to ward off disease. When our people come to see this, they will also understand that none of the proposals to redistribute medical services at the taxpayer's expense will ever prevent sickness or have, in fact, anything at all to do with health. They will judge these schemes for what they really are, i.e., state-supported and administered forms of compulsory insurance against some of the costs of illness. Likewise they will see that most of the causes for rejection by the Selective Service in this war are not medical problems at all but problems in nutrition.

True health is not just being able to keep out of a physician's office or from buying nostrums at the corner store. On the contrary, health is a positive thing by which we may, if we but turn to the teachings of this little book, keep our bodies from disease, enjoy every moment, and live through a long and useful old age. When people are physically fit, they are alert. They have endurance and do not tire easily. Furthermore, they can think straight. They are well-balanced emotionally. They do not worry. They meet the problems of life with common sense and make the necessary social adjustments without any fuss. Most of the strange reactions and unusual ideas in our social evolution come from brains that are improperly nourished! It is true, of course, that our worries and emotional states do great harm at times to our bodies, but they almost always begin in a nervous system that is a victim of some "hidden hunger".

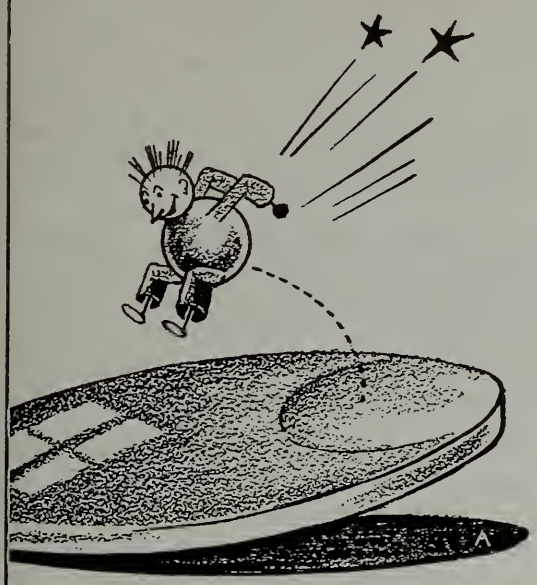
So if we are to have children whom we can educate and who will think straight about our social and economic problems, if we are to abolish the so-called degenerative diseases and substitute a vigorous productive old age for senility, if we are to give our people the mental and physical capacity to do the tremendous job that lies ahead without rebelling, and if we are to give to them the fortitude and the courage that is going to be necessary in each of us for the job of rearranging this world so that an enlightened and happy Republic can survive, it will take the very best state of nutrition and fitness in the bodies of everyone of us.

This fourth edition of this successful work on "Nutrition and Physical Fitness" gives all that is needed to attain this objective. We physicians must see to it that the spirit of this text, as I have tried to interpret it, as well as the facts it so clearly presents, must have a wide circulation and that right promptly if our country and its way of life are to survive.

Minor Surgery, edited by Humphry, Rollston & Allen, Moncrieff, ($5.00. *Philosophical Library, Inc., New York City)* presents 18 chapters by 18 distinguished British surgeons. For all this, the subject is condensed into 155 pages with 30 illustrations. It is written with the brevity and clarity so outstanding in the ranks of our confreres.

The March of Medicine. The New York Academy's Lecture to the Laity, 1943, ($2.00. *Columbia University Press, New York City)* is the ninth in this annual series. Again the lectures are of timely interest. They are six in number: "Crime and Punishment", by Bernard Glueck of Stony Lodge Foundation; "The Scientific Method and our Plans for Peace", by Sir Norman Angell, Nobel peace prize winner, 1933; "War and Medicine", Edgar Erskine Hume, Colonel, M. C., U. S. A.; "Aggressiveness—Individual and Collective", Franz Alexander, M. D.; Institute for Psycho-Analysis, Chicago; "Let Babies Be Our Teachers", Myrtle C. McGraw, Ph.D., Normal Child Development Study; "Nature and Man", The Lindsey R. Williams Memorial Lecture by Robert R. Williams, D.Sc., Bell Telephone Laboratories. The Committee deserves high praise for getting these lectures to us in this form.

Invitation to Health. A Guide to Successful Living, by Harry J. Johnson, M.D., ($2.75. *Prentice-Hall, Inc., New York City)* is a sensible health book written by the medical director of



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the Life Extension Institute and its examiners. In this work, the salient principles of good health are presented with great care not to offend or frighten.

Mental Hygiene. The Psychology of Personal Adjustment, by D. B. Klein, Professor of Psychology, University of Texas, ($2.80. *Henry Holt, New York City)* is a general introductory text in the field. It attempts to orient the young professional student and, at the same time, meets the needs of the non-professional reader. A good deal of space is devoted to the promotion of mental health.

Fundamentals of Psychiatry, by Edward A. Strecker, M. D., ($3.00, 2nd Edition. *J. B. Lippincott Company, Philadelphia)* has been written by this eminent authority because, at this time, it is exceedingly important that all physicians be well versed not only in the routine of practice, but in an understanding of the principles of the various specialties. Of these certainly, at this time, none is as important as psychiatry.

How to Raise a Healthy Baby. Complete Information from Birth to the Sixth Year, by L. J. Halperen, M. D., ($1.95. Sixth Printing. *Prentice-Hall, Inc., New York City)* is a handy reference book by the eminent Chicago pediatrician.

Creating Body Beauty. A Woman's Guide to Charm, Poise, and Personality, by Marguerite Agniel, ($2.00. *Bernard-Ackerman, Inc., New York City)* is a sensible presentation of physical culture. The author is an international dancer and an exponent of the body beautiful.

The Sulfonamide Therapy in Medical Practice, by Frederick C. Smith, M. D., ($5.00. *F. A. Davis Co., Philadelphia)* is, as George M. Piersall says in the Introduction, "a well-considered review of this much-discussed but often poorly understood subject".

Seafood Cookery, by Lily Haxworth Wallace, ($2.00. *M. Barrows & Co., Inc., New York City)* is a complete handbook for every kind of fish cooking with menus and suggestions for serving. Your reviewer has established quite a reputation as an authority in this field, but he welcomes this as a great addition to his library.

Female Endocrinology Including Sections on the Male, by Jacob Hoffman, M.D., ($10.00. *W. B. Saunders Co., Philadelphia)* presents a full discussion in nearly 800 pages of the subject which is so frequently encountered by every physician who is consulted by women. Every one who is interested in functional disorders cannot afford to be without this book.

Traumatic Injuries of Facial Bones. An Atlas of Treatment, by John R. Erich, M.D., and Louie T. Austin, D.D.S., ($6.00. *W. B. Saunders Co., Philadelphia)* is another well-planned and executed military manual written for the Navy by these two experts at the Mayo Clinic.

Rose's Foundation of Nutrition, revised by Grace Macleod and Clara Mae Taylor, ($3.75. 4th Edition. *The Macmillan Co., New York City)* brings up to date the classical text of the late Mary Swartz Rose. It still continues to be one of the outstanding texts in the field.

Shipboard Medical Practice, by W. L. Wheeler, Jr., M.D., ($1.00. *Cornell Maritime Press, New York City)* is a handbook on ship sanitation and emergency medical aid at sea by the medical director, Grace Line. It is directed to seamen.

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Symposium on Alcoholism Scheduled For Cleveland, Sept. 12 and 13

Meetings of the Symposium on Alcoholism to be conducted by the Research Council on Problems of Alcohol in Cleveland, September 12 and 13, will be open to members of the Ohio medical profession.

The latest developments in the diagnosis and treatment of alcoholism will be described at the symposium, which is being held in connection with the annual meeting of the American Association for the Advancement of Science. Four major subjects of outstanding importance will be introduced to the symposium by scientific papers. These will serve as the basis for round-table discussion. Other papers will present new scientific and medical knowledge about alcoholism.

Dr. Anton J. Carlson, President of the Research Council on Problems of Alcohol, will present his views on the conditioned reflex treatment of alcoholism.

Dr. Harry M. Tiebout, physician-in-charge, Blythewood Sanitarium, will set forth findings on non-psychotic cases of chronic alcoholic addiction.

Psychotherapy of alcoholics, especially of those without psychosis, will be discussed by Dr. Edward B. Allen, senior resident physician, New York Hospital, Westchester Division.

How the Rorschach Analysis can be helpful, in the initial examination of patients with an alcohol problem, as an aid in differentiating between the psychopathic, the schizophrenic, the feeble-minded, the organic, the neurotic, and the mixed-picture alcoholic, will be the subject of a paper by Dr. Robert V. Seliger, assistant visiting psychiatrist, Johns Hopkins Hospital, Baltimore.

Those physicians interested in Alcoholics Anonymous will find its program one of the principal subjects of discussion by the round-table on group aids to therapy. Comprising the round-table will be persons such as Dr. Lawrence Kolb, U. S. Public Health Service; Dr. George Stevenson—Medical Director, National Committee for Mental Hygiene; Lieut. Comdr. Florence Powdermaker, Chief of Health Education, War Shipping Administration; Dr. Frank F. Tallman, recently appointed Commissioner of Mental Diseases for Ohio, and representatives of Alcoholic Anonymous and the Salvation Army.

Ohio physicians planning to attend are requested to notify Dr. George S. Stevenson, at the Research Council on Problems of Alcohol, Room 812—60 East 42nd Street, New York 17, New York, and to indicate the sessions they are interested in. The meetings will be held in Rooms 31 and 34, Hotel Cleveland. There will be no charge for admission.

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Activities of County Societies

CLINTON

Members of the Clinton County Medical Society held their annual picnic July 4 at Dr. Frank Peelle's Camp. The attendance was large, and an excellent dinner was enjoyed. Dr. J. H. Frame, Wilmington, spoke on "Extra-uterine Pregnancy". The society approved a plan for medical care of transient farm workers.—R. W. DeCrow, M.D., secretary.

ADAMS

Dr. S. C. Clark, Cherry Fork, was host to members of the Adams County Medical Society and their families at a meeting of the society, August 16. "Diseases of Right Upper Quadrant", was the subject of the program, with Dr. E. Schlueter, Cincinnati, presenting the medical phases; Dr. R. B. Ellison, Peebles, X-ray; and Dr. J. E. Pirrung, Cincinnati, surgical.—H. L. Sproull, M.D. secretary.

GREENE

Three medical officers from Patterson Field furnished the program for a meeting of the Greene County Medical Society, July 6, at the courthouse, Xenia. Capt. Lloyd Larrick spoke on "A New Method of Continuous Spinal Anaesthesia", and Lt. Col. George Riggs and Capt. Robert Nixon discussed "Peripheral Vascular Disease".—News clipping.

Physical Therapy Congress

The American Congress of Physical Therapy will hold its twenty-third annual scientific and clinical session September 6, 7, 8 and 9, inclusive, at the Hotel Statler, Cleveland. The annual instruction course will be held from 8:00 to 10:30 A.M., and from 1:00 to 2:00 P.M. during the days of September 6, 7 and 8. The scientific and clinical sessions will be given on the remaining portions of these days and evenings. All of these sessions will be open to the members of the regular medical profession and their qualified aids. For information concerning the instruction course and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago 2, Illinois.

Named Stearns & Co. Manager

The Board of Directors of Sterling Drug, Inc. have elected Dr. J. Mark Hiebert as divisional vice-president and general manager of its Frederick Stearns & Company Division in Detroit.

Dr. Hiebert has been associated with Sterling Drug Inc. since 1934. He received his M.D. degree from Boston University Medical School.

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Procedures Given For A.S.T.P. Medical, Dental Programs

Procedures for disposal of certain enlisted personnel in the Army Specialized Training Medical Program necessitated by provisions of the Military Appropriations Act, 1945, have been announced by the War Department. The act, approved June 28, 1944, stipulated that none of the funds appropriated shall be used for training medical and premedical students unless they were in training prior to June 7, 1944, and such training was defrayed from 1944 appropriations.

At the same time, it was announced that the A.S.T.P. dental training program is being terminated at the close of the present semester except for those in the senior, or final, year, who will be permitted to complete the course and on graduation will be commissioned. This action is taken because the Army's requirements for dentists are now filled.

Those individuals now on active duty whose medical or premedical educational expenses were defrayed in whole or in part by the government under the A.S.T.P. program prior to June 7, 1944, will be continued in the medical program of the A.S.T.P. Those on active duty whose medical or premedical training was not defrayed either in whole or in part under the A.S.T.P. program prior to June 7, 1944, and who for that reason cannot be continued in the training program fall into two classes who will be disposed of as follows:

1. Those who have letters of acceptance and who would have entered an accredited medical school by Dec. 31, 1944. An individual in this group may elect to be discharged from the Army shortly before the entrance date of the class for which he was accepted; or to be assigned to the Medical Department with no further A.S.T.P. medical training.

2. Those who do not have a letter of acceptance to an accredited medical school, for entrance by Dec. 31, 1944. These men will be continued on active duty and will not be eligible for A.S.T.P. medical training.

Radio Records Available From A.M.A.

Radio "platter" (transcription) broadcasts, produced by the Bureau of Health Education of the American Medical Association, are available to county medical societies and to health departments with the approval of county medical societies, for use by local radio stations. Topics include: Before the Doctor Comes; Dodging Contagious Diseases, and American Medicine Serves the World at War. Requests for use of these broadcasts should be addressed to the Bureau of Health Education, American Medical Association, 535 N. Dearborn St., Chicago 10, Ill.

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Through August 15, 1944, cases of infantile paralysis reported to the State Department of Health numbered 245, with 13 deaths. Comparable figures for the same period in 1943 were 29 cases and 3 deaths. Total cases reported during 1943 were 184, with 12 deaths.

* * *

Dr. Leon Goldman, assistant professor of dermatology, University of Cincinnati College of Medicine, was granted a fellowship by the Association of American Medical Colleges to study during July and August in Costa Rica, Guatemala and Mexico.

* * *

The Board of Directors of the Academy of Medicine of Cleveland has approved a plan for an Academy gift of $25 in credit against local dues to members returning from military service. This will be in the nature of a gift, not an obligation, and the eligibility of each man for such a gift will be determined separately.

* * *

Dr. E. T. Crawfis, assistant superintendent and psychiatrist at the Lima State Hospital, has been appointed superintendent of the Cleveland State Hospital. He succeeds Dr. H. P. Lee, who returns to the staff of the Toledo State Hospital.

* * *

The Columbus field office of the Social Security Board has been moved from its present quarters in the Ohio State Savings Building to 302 Old Post Office Building, southeast corner of State and Third Streets.

* * *

In four and one-half years, The Hospital Care Corporation of Cincinnati has enrolled 40 per cent of the total population of the area served. This is said to be the fastest growing Blue Cross Plan in the United States.

* * *

Dr. Earl R. Burbidge, Philadelphia, for the past three years with the medical research division of Sharpe & Dohme, is the new medical director of Frederick Stearns and Company, Detroit. He graduated at the Washington University School of Medicine, St. Louis, in 1939.

* * *

Despite reductions in travel, traffic accidents on Ohio's rural state highway system for the first six months of 1944, are 27 per cent above the same period in 1943.

* * *

Dr. Harry E. LeFever, Columbus, represented the Ohio State Medical Association, at a meeting of the Ohio Division, National Foundation for Infantile Paralysis, July 23, at Columbus. Speakers included: Dr. John A. Toomey, Cleveland; Dr. R. H. Markwith, State Director of Health; and Dr. John Lavan, formerly of Toledo, now director of research for the Foundation.

* * *

The Hospital Campaign Corporation of Cleveland was recently incorporated for the purpose of raising funds to build and equip three new hospitals in Cleveland, at an estimated cost of $3,000,000.

* * *

Dr. John A. Toomey is acting director of pediatrics at Western Reserve University School of Medicine, and acting director of Babies' and Children's Hospital, succeeding Dr. Henry J. Gerstenberger, who has been granted a leave of absence.

* * *

Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, was one of the speakers at the School and Community Health Education Conference held at Ohio State University, Columbus, under the auspices of the State Department of Education during the week of August 21.

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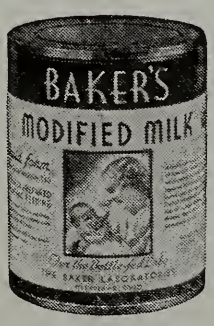
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Cincy Doctors Get Taste of Rigors of Practice in the "Big Woods"

Three Cincinnati physicians, one of them in the role of a patient, had a first-hand experience of medical practice in the wilderness country of Lochsa county in Northern Idaho early in August. Drs. Ralph W. Eddy, Paul I. Hoxworth and Robert A. Kehoe, with Mrs. Eddy, Mrs. Hoxworth and Miss Kathleen Kehoe, were living in tents while on a trout-fishing vacation in one of the remote sections of the Rocky Mountains, 110 miles from Missoula, Montana, the nearest town and many miles from any highway. The party had reached the camp by pack train and horseback. Late one afternoon Dr. Eddy developed acute appendicitis. Drs. Hoxworth and Kehoe decided that an immediate operation was necessary. They traveled by horseback to the nearest habitation, a U.S. Forestry Service lookout station high on a neighboring mountain. The ranger in charge drove the men to the nearest ranch house, 45 miles away, over a narrow, hazardous mountain road. At the ranch house another car was obtained and the 65-mile trip to Missoula over another winding narrow road was begun. By 4 A. M. Dr. Eddy was on the operating table, and Dr. Hoxworth completed the appendectomy a short time later. The latest report was that the patient is convalescing satisfactorily.

Think Twice Before Answering

Several Ohio physicians have received a postal card over the signature of "Anthony Seward, 1148 West Chicago Avenue, Chicago 22, Illinois", reading as follows: "I would like to enter into an arrangement with you, requiring your full time service away from your office. If you are willing to leave town can offer you an attractive opportunity with a permanent arrangement. This is permanent in Ohio, with a definite weekly guarantee. If you are interested and available for any part of your state, wire me (collect) at once and I will contact you and make further arrangements. Please give me your telephone number so that I can call you. Thanking you for an immediate reply, I am."

The Executive Secretary of the Ohio State Medical Association, when informed, wrote Mr. Seward in part as follows: "If you would care to submit to me something about yourself and what your proposition is, I would be in a position to answer this and probably other inquiries intelligently. Otherwise, I would have to tell those inquiring that I know nothing about you and in all probability they should disregard your communication."

There has been no reply to that inquiry. Therefore, it would be wise for physicians receiving such a postal card to think twice before carrying on any negotiations.

Ordinance Banning Ads on Price Of Lenses is Upheld

An ordinance of a municipal corporation which provides that "no person, partnership, corporation, or agent or employee therein engaged in or connected with the sale of eyeglasses, ophthalmic lenses, eyeglass frames and mountings, shall include in any advertisement by newspaper, radio, display, or otherwise, any statement advertising the price of lenses, or of complete eyeglasses, including lenses, either with or without professional services or credit terms, instalment payments or price plans", is a reasonable and valid exercise of the police power and is not violative of the Federal or state Constitution, the Ohio Supreme Court ruled on August 2, (No. 29889) upholding a decision of the Second District Court of Appeals and reversing a decision of the Springfield Municipal Court in the case of the City of Springfield vs. Hurst.

Gallipolis—Acting superintendent of the Ohio Hospital for Epileptics for a year, Dr. John G. Schwarz has been appointed superintendent by the State Department of Public Welfare. A native of Cincinnati, Dr. Schwarz has been connected with the institution for 32 years, first as a staff physician and for ten years as assistant superintendent.

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JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.* GEORGE H. SAVILLE, *News Editor*

Functional and Organic Diseases of the Gastrointestinal Tract: Physiological and Medical Considerations

A. C. IVY, PH.D., M.D.

WHEN assigned a general subject it is a difficult task to make an appropriate selection of the subject matter to be presented, because the subject can not be covered in one hour. I shall deal with those conditions which appear to be the most important.

You probably know that functional and organic disturbances of the alimentary tract rank high among the causes of medical morbidity in our Armed Forces. The medical director of a large corporation recently informed me that the majority of the medical patients seen by his group had functional gastrointestinal disturbances and peptic ulcer.

In regard to functional gastrointestinal complaints, I do my best to emphasize (a) that we should not be satisfied with the diagnosis of a functional disturbance until organic causes have been thoroughly eliminated, and (b) that functional disturbances of the alimentary tract may be secondary to disease in other systems. Perhaps the system most frequently overlooked as a cause of dyspeptic symptoms is the urinary tract. But, no physician today overlooks psychogenic factors, though frequently he can do nothing to correct the economic, domestic, and personality defects which serve as the source of the psychogenic factors. As many have suggested, such patients may have to return to "the old ways of living" where living is not so "fast", tense and irregular.

PEPTIC ULCER

I shall speak first regarding the old problem of peptic ulcer, not so much because it is timely but because there are three items of new information regarding which the majority of you will be interested. Of course, peptic ulcer is an important disease. It causes a great amount of morbidity. And death from ulcer of the stomach and duodenum, in the adult above the age of 35, ranks third among the diseases of the alimentary system. Ulcer of the stomach causes death more frequently than ulcer of the duodenum.

The effect of emotions on gastric secretion. Victims of peptic ulcer are frequently described as being "high strung, nervous, worrying, aggressive, gogetting, inwardly tense but outwardly poised, as failing to relax well even when they go to bed and sleep," etc. It has also been said that peptic ulcer develops in certain soldiers when they are waiting for combat or retreating, and disappears when they go into action. Neurocirculatory asthenia is said to appear in the converse situation.

It is well established that anxiety, fear, disgust and great elation usually depress gastric secretion and motility. Wittkower, however, has reported that gastric secretion is increased by

The Author

● Dr. Ivy, Chicago, Ill., is a graduate of Rush Medical College, University of Chicago, 1922; member, American Gastro-Enterological Association, American College of Physicians, and the American Physiological Society, Chicago Institute of Medicine; and Nathan Smith Davis professor of physiology, Northwestern University Medical School, Chicago.

Presented at the First General Session, Ninety-Eighth Annual Meeting of the Ohio State Medical Association, Columbus, May 2-4, 1944.

such emotions in some persons. Todd observed a number of years ago that, although most medical students manifest a depression of gastric motility when anxious, some of them respond by manifesting hypermotility and spasm.

Quite recently Wolf and Wolff[1] studied the problem in a patient with a large gastric fistula. In this subject they found that "during periods of experimentally induced anxiety, hostility and resentment" gastric acidity and contractions increased and the gastric mucosa became more vulnerable to trauma and gastric erosions appeared. On studying patients with "peptic" ulcer and in some normal subjects they found the stomach to manifest increased acidity and motility when similar emotional states were produced[1]. These observations constitute the best evidence available showing that "stress and strain" may cause changes in the stomach which predispose to peptic ulcer.

Whether similar changes occur in the duodenal antrum is not known, which is important because that is where most peptic ulcers occur and because duodenal ulcer is more frequently associated with a hypersecretory response to a stimulus and with a hypercontinuous secretion than gastric ulcer.

Neither do the observations explain the tendency of most ulcers to recur in the Fall and Spring, the Spring increase being real according to our statistical studies. The explanation that this is due to the greater incidence of infections lost acceptance with the decline in the belief of the importance of the bacterial etiology of peptic ulcer. However, Wolf and Wolff were impressed by their observations regarding the protective role of mucus against trauma and ulceration. In this connection it is of interest that when one extracts mucus from the mucosa of the stomach of the pig more is obtained in the Winter than the Spring months. The reason for this is not clear, but it does show that a seasonal change occurs in the gastric mucosa of the pig.

Caffeine containing beverages. Though many physicians and textbook authors interdict smoking and the use of alcoholic beverages in the management of peptic ulcer, none have done so in respect to caffeine containing beverages.

My interest in the effect of caffeine was not aroused until a physician told me that he was unsuccessful in managing a patient with peptic ulcer until the patient had reduced the intake of a popular caffeine containing beverage from 24 to 12 bottles a day. About the same time Dr. Judd[2] found that the administration of caffeine (5 grains) in bees' wax subcutaneously to retard the rate of absorption caused gastric and duodenal ulcers in cats. This we (Roth, Atkinson and Ivy) have confirmed. In addition it has been found that the slow intravenous injection of caffeine with histamine stimulates gastric secretion and within an hour or two under direct observation of the stomach one can observe erosions of the mucosa develop. Gastric secretion in man is also stimulated by caffeine, and on a body weight basis, provided the stomach of man is as susceptible as the cat's, 30 to 60 grains of caffeine should cause erosions in the stomach.

Caffeine and histamine have a synergistic action in stimulating gastric secretion in man and the cat. This is important to the ulcer patient, provided that portion of his gastric secretory response which can't be abolished with atropine is due to histamine. That it is due to histamine is supported by strongly presumptive evidence.[3] Alcohol and caffeine have a definitely additive action in stimulating gastric secretion.

Coffee stimulates gastric secretion due to its content of caffeine and due to the presence of gastric secretagogues produced apparently by the roasting process. Beverages produced by roasting grains stimulate gastric secretion but not to the extent of coffee.

The effect of a caffeine test meal on gastric secretion has been studied in over 50 "normal" subjects and in 25 patients with "peptic", chiefly duodenal, ulcer to date. All the peptic ulcer patients (under management) manifested a hypercontinuous output of acid in that, instead of returning to the control level in one hour as the normal subjects, they continued to secrete for two or more hours. Five of our "normal" subjects responded like the ulcer patients. Two of these have developed duodenal ulcer within the last two months and another is disturbed with lower substernal distress.

It is believed that these observations warrant the following statements. In the management of peptic ulcer the consumption of coffee and caffeine containing beverages should be minimal. Persons susceptible to peptic ulcer should abstain from or limit their intake of caffeine containing beverages. The further study of the phenomenon of the hypercontinuous response of ulcer patients to caffeine may prove to be a method for the determination of predisposition to ulcer.

GASTRIC CARCINOMA

Cancer of the stomach, liver and gallbladder comprise almost one-third of the total of all forms of cancer. Cancer of the stomach in males causes more than twice as many deaths as cancer of any other single organ and ranks second only to the uterus in females.

What can the physician do to decrease deaths from cancer of the stomach? To answer this question a few statistical observations must be recalled.

The clinical history of patients with gastric cancer shows that dyspeptic symptoms have been

present in the patient for an average of only six months before the physician is consulted and for somewhat less than one year before the diagnosis is made. The situation is made worse by the fact that more than 50 per cent of the cancers have spread beyond the stomach when the first symptoms appear. When the cancer is not near the cardia or pylorus, symptoms appear late, or not until the symptoms of obstruction, bleeding, secondary infection and metastases occur. This means that in order to decrease deaths from 50 per cent of the cancers of the stomach the public will have to be educated to report to the physician for an X-ray examination as soon as dyspeptic symptoms occur after the age of 40. In order to significantly reduce deaths from the remaining 50 per cent,—those which spread before causing symptoms,—an X-ray examination would have to be made every three months past the age of 40.

If the stomach were examined every three months it is probable that death from cancer of the stomach could be reduced by about 90 per cent. In most cases it can be readily diagnosed early. It is difficult for the physician to advocate actively such a matter because he will be criticised as mercenary. However, it can be advocated by pathologists, physiologists and non-professional agencies.

The only thing the physician can do is to manifest "eternal vigilance" and not apply palliative therapy without an X-ray examination of the stomach. This is advisable for several reasons. Today gastric cancer is a more common lesion than chronic gastric ulcer. About 2.5 per cent of all deaths are due to cancer of the stomach, and 1.1 per cent are due to cancer of colon, rectum, peritoneum and intestine; 56.9 per cent of deaths from cancer in males arises in the digestive tract and 40.2 per cent in females.[4,5]

We all know that in about 10 per cent of patients which show niches or craters in the stomach, it is not easy to decide whether the crater is due to a chronic gastric ulcer or to a carcinomatous ulcer. In these cases I believe it is better to err on the side of an unnecessary operation than to miss the early diagnosis of gastric cancer. If with rest in bed and on strict ulcer management the ulcer does not show some healing in two weeks and is not healed in four to six weeks, I believe an operation should be performed depending to some extent on whether the X-ray mucosal relief pattern shows radiating folds of mucosa about the crater. Even then it is now known that some cases of carcinomatous ulcer will heal completely.

Thus, if a material decrease in the incidence of deaths from gastric cancer is to be obtained in the future the public will have to be educated to consult the physician earlier and much more frequently than in the past and the physician must manifest alert vigilance regarding the matter in patients above the age of 40.

LIVER AND BILIARY TRACT

Hepatic disease ranks next to cancer of the digestive organs as the cause of death in persons above 45 years of age. **Cirrhosis of the liver** heads the list among the hepatic diseases which cause death.[4,5] Death from **biliary calculi** ranks next, but it is only about one-half as frequent as death due to cirrhosis. Biliary calculi, of course, rank very high as a cause of morbidity, especially in women, but in view of the early diagnosis and surgical treatment of this condition, deaths from biliary calculi are relatively very low today.

Cirrhosis of the liver will probably increase in the next two decades because of the increased consumption of alcohol, of exposure of a larger number of people to industrial hazards, and of the necessary exposure of our men in the Armed Forces to various sorts of agents which deleteriously affect the liver. Since dyspeptic symptoms are the earliest symptoms of this disease, all patients with such symptoms should be studied by testing their hepatic reserve and by examining for the signs of portal hypertension. If diagnosed early and the newer methods for the treatment of hepatic degenerative processes are applied, there is basis for the hope that the disease may be arrested, or at least, that life may be definitely prolonged.[7]

The most important, difficult and practical feature of hepatic biliary tract disease is the early **differential diagnosis of jaundice**, or the differentiation of medical and surgical jaundice. An outline of this differential diagnosis will be presented tomorrow.[7] However, I believe, I should mention here that all patients, in my opinion should be hospitalized at the onset. The earlier an extrahepatic obstructive jaundice is recognized, and the patient adequately prepared for an operation and operated, the better off is the patient. The preoperative and medical management of the jaundiced patient is basically the same, except for uncomplicated hemolytic jaundice, and other relatively uncommon diseases.

According to the experience of Carter, Greene and Twiss[8] and Walters and Snell[9] about two-thirds of the cases of jaundice in the adult are due to cholelithiasis and carcinoma of the pancreas. It is worthwhile to reproduce for teaching purposes the observations of Carter, Greene and Twiss (Tables 1 and 2).

I know of no well-controlled study of the use of sulfa drugs in **acute cholecystitis.** Because of the occasional occurrence of hepatitis with jaundice after the administration of **sulfa drugs**, the presence of hepatitis has been considered to be a **contraindication.** If the drug should be used, the liver of the patient should be well fortified

beforehand by the administration of carbohydrate and protein,[7] or by intravenous glucose if the patient is too sick to eat. Since **penicillin**, according to existing information, seems to be

TABLE 1

Frequency With Which Various Diseases of the Biliary Tract Were Found in Patients Having Jaundice.

DIAGNOSIS	Total No. of Cases	Jaundice Incidence per cent	Jaundice No. of Cases
Colelithiasis	1832	476	52
Cholecystitis	1290	176	19
Carcinoma	238	119	12
Hepatitis	78	78	8
Cirrhosis	122	48	5
Miscellaneous	47	29	3
TOTAL	3607	926	100

TABLE 2

The Frequency With Which Jaundice Occurred in Various Diseases of the Biliary Tract

DIAGNOSIS	No. of Cases Total	No. of Cases With Jaundice	Incidence of Jaundice per cent
Hepatitis	78	78	100
Miscellaneous (common duct obstruction)	47	29	61
Carcinoma	238	119	50
Cirrhosis of liver	122	48	39
Cholelithiasis	1832	476	26
Cholecystitis	1290	176	14
TOTAL	3607	926	100

devoid of any hepatotoxic effect, it may prove to be very useful in the management of acute cholecystitis with or without jaundice.

Cholelithiasis is, of course, an organic condition. But, the cause of gall stones has been considered to be infectious, metabolic or functional in nature. Small pigment and calcium containing calculi have been produced experimentally on an infectious basis and it is known that patients with hemolytic jaundice develop pigment calculi. A fatty liver produced in guinea pigs by feeding cholesterol is associated with the formation of calcium phospate stones,[10] and the fatty liver produced in dogs by a low protein-high fat diet is associated with the collection of sediment in the gallbladder.[11] No one has produced in the gallbladder, the mixed cholesterin stones most frequently found in the human gallbladder. However, prolonged stasis in the bile ducts associated with biliary cirrhosis has yielded stones not unlike human stones.[12] When gall stones like those most frequently found in the human gallbladder have been produced experimentally, I seriously suspect that stasis in the gallbladder will be an important part of the process.

Stasis, in fact, would logically seem to be the **sine qua non** for the formation of gall stones, because how could they form otherwise unless they were attached to the wall of the gallbladder until they were too large to be evacuated. It is established that sediment can be evacuated from the gallbladder[13] by giving egg yolks and cream but not by giving bile salts.

Because stasis predisposes to gall stone formation, functional disturbances of the biliary tract deserve consideration. In addition it has been demonstrated that in the presence of "spasm" or functional obstruction at the level of the sphincter of Oddi, distension of the common duct or contraction of the gallbladder in man will cause biliary tract distress. The evidence on which that statement is based has been summarized elsewhere.[14]

Biliary dyskinesia or dyssynergia is an expression which refers to an ill-motion of or lack of coordination between the sphincter of Oddi and gallbladder.[15] Although some believe that the sphincter of Oddi is affected by nervous or emotional states in man, this has never been demonstrated,[17] though the sphincter in laboratory animals is affected by the splanchnic and vagus nerve.

The role that biliary dyskinesia plays clinically has been considered adequately by Walters and Snell,[9] Carter, Greene an Twiss[8] in their books, and by Hill.[16] I shall refer only to two points regarding the subject; one pertains to the differential diagnosis and the other to the postcholecystectomy syndrome.

I have seen patients with right hypochondral neuralgia which had been diagnosed as biliary dyskinesia. I have seen two patients with a minor coronary occlusion which had been diagnosed as biliary dyskinesia. I have seen the diagnosis of biliary dyskinesia made in a case in which non-specfic ulcerative colitis started in the hepatic flexure of the colon; at least the colon was spastic in that segment with occult blood in the stools and colitis appeared in the distal colon two months later.

To confuse the symptoms of a spastic colon or of the so called duodenal pre-ulcer syndrome with those of biliary dyskinesia is understandable. This is because in laboratory animals it has been shown that colonic or doudenal irritation can cause the sphincter to contract and to remain contracted for some time.[14] This, however, has not been demonstrated in man. But, it has been my experience and that of others, that symptoms of biliary tract distress and associated delayed evacuation of the gallbladder disappear when the spastic colon or the so called pre-ulcer symptoms have been adequately managed. This shows either that the biliary tract symptoms were false or that irritation of the duodenum or colon caused the biliary tract distress.

In the postcholecystectomy syndrome it is important to rule out organic factors as a cause of biliary tract distress before the diagnosis of dyskinesia is made. I have already referred to some of the conditions which might be diagnosed

erroneously as dyskinesia and which would not be relieved by an ill-advised cholecystectomy.

Also, after a gallbladder, which should have been removed, has been removed, various degrees of **cholangitis, pancreatitis and hepatitis** may persist and cause trouble. Incomplete stricture of the common duct, which is relatively easy to injure, may cause distress. **Putty-like** material may accumulate in the ducts, or **small stones,** missed at operation, may be present and cause distress, without necessarily causing intermittent jaundice. **Post-operative angulation of the duodenum** or adhesions may be concerned. The intramural portion of the common duct may harbor a low grade infection. Or, as emphasized by Cole and Rossiter,[18] the cystic duct stump may contain a stone, be inflamed or kinked by adhesions. A number of years ago Dr. Shrager and I found the cystic duct to be especially sensitive to distension in dogs.

Theoretically if the "sphincter of Oddi" is hypertrophied or hyperirritable, it will not necessarily be relieved by cholecystectomy. That the sphincter may be hypertrophied in man has been clearly demonstrated by Giordano and Mann.[19]

I have previously discussed the treatment of this condition before this Association.[20] In addition to the treatment recommended in the article referred to, some use belladonna; others give a small dose of heavy magnesium oxide before meals.

As a result of our studies on the effect of foods and bile acids on the formation of bile, I have recommended for cholecystectomized patients a relatively high protein diet, with the usual amount of carbohydrate, and relatively low fat.[17] Such a recommendation was made because protein increases the formation of bile by increasing the formation of bile salts and excessive fat and carbohydrate, at the expense of protein, decreases the formation of bile. This diet should be prescribed for all cholecystectomized patients to keep the bile thin and flowing. If one has a non-cooperative patient in regard to dietary management, I should prescribe dehydrocholic acid, known best under the trade name of Decholin, Ketochol, Kiebeloc, Degagol, etc., to keep the bile thin and flowing.

Time does not permit a consideration of the pancreas, small intestine, appendix and colon.

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Facial Deformity and Change in Personality Following Corrective Surgery

It has long been recognized that there exists in the minds of normal individuals an inherent desire to look their best and this desire assumes the role of vanity only when it changes to love of indiscriminate admiration. It is also generally admitted that the psychic component usually bears relationship to the organic; that is to say, the greater the deformity the more notable the psychic trauma, although occasionally minor anomalies cause profound psychic reactions. It is common observation that the everpresent consciousness of an inferior appearance, particularly if congenital or acquired in early life, tends to thwart the normal development of the personality. After these patients reach adolescence and from the day they are assured much can be done to improve their appearance, there is a marked change in the morale.

The more pronounced facial deformities usually exhibit the so-called shut-in personality. The eyes are dull, the expression is languid, there is a delayed reaction to surrounding stimuli, they respond inadequately to social appeal and the picture is generally framed with almost total lack of animation. Diagnosis in many of these cases requires the combined knowledge of both medical and dental specialists, for in addition to careful physical examination, study of photographs, facial casts and dental impressions are essential. —Charles M. MacKenzie, M. D., Spokane, Wash. Northwest Med., Vol. 43, No. 8, Aug., 1944.

Tropical Diseases: Their Geography, Biology, and Prevalence

WILLIAM McKEE GERMAN, M.D.

WHEN tropical diseases are mentioned most of us think of strange exotic maladies something out of this world, to use the present day vernacular, something to push aside because it does not concern us.

There is no sharp dividing line between the tropics and the temperate zones. With present day communications and the mass movements of people in and out of the tropics, our notions of the geography of disease must be revised. We have come to the point when we may have to discard the term tropical medicine and speak of geographic medicine. The tropics have every disease that we have and, in fact, near or on the equator, are regions whose climate reminds one of Norway.

COMMUNICABLE

When one thinks of tropical diseases he invariably thinks of the communicable diseases of the tropics. These diseases broadly speaking, have certain very important differences from the communicable diseases of our climate. We may outline these differences in the following table:

COMPARISON OF TROPICAL AND TEMPERATE ZONE DISEASES

	Tropical	Temperate Zone
Endemic	Many	Few
Epidemic	Few	Many
Seasonal Fluctuation	Little	Marked
Animal Parasite Etiology	Many	Few
Bacterial Etiology	Few	Many
Virus Etiology	Few	Many
Rickettsial Etiology	Few	Many
Transmission Direct Man to Man	Few	Many
Transmission by Insect Vector	Many	Few
Required Host Reservoirs Animal or Human	Many	Few
Subject to Control by Vaccines or Sera	Few	Many

After a little study of this table, I think it becomes obvious that the prevalence of certain diseases in the tropics and their infrequency among us depends upon three sets of factors:

1. Available reservoirs, either animal or human, which periodically or continuously carry the specific organisms.

2. A climate that favors both the propagation of vectors (usually insect), and the completion of the developmental cycle of the organisms in that vector.

Read before the Annual Meeting of the Allegheny County Medical Society, Pittsburgh, Pa., May 9, 1944.

The Author

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3. The manner in which people live that puts them in relation with vectors and reservoirs.

AVAILABLE RESERVOIR

A typical case of an available reservoir is Yellow Fever. The natural reservoirs of the virus of this disease are several species of jungle animals. The virus circulates in the blood of these animals for a period of a few days, to then disappear as specific antibodies are developed. During this period of free circulation, the virus is available for certain species of jungle mosquito (Hemogogus). The mosquito takes up the virus with its blood meal and in turn subsequently transfers it to a susceptible human.

Malaria is another tropical disease requiring a reservoir. Man in this case is that reservoir, since no known animals have been found that harbor the common plasmodia of man's malaria. For malaria to maintain itself, there must be available for the anopheline mosquito a sufficient number of human hosts in whose blood circulate the gametes of the plasmodium. Should we deny the anopheline its human blood meal, the cycle would be broken and malaria would soon disappear.

Again, malaria may be used as a disease whose prevalence is determined by climate. Under climate may be included mean average temperature, annual rainfall, minimal seasonal variations, high humidity and other factors which favor the propagation of anopheline mosquitoes and at the same time determine the length of time required for the sexual stage of the malaria parasite to be completed within the infected mosquito.

A climate without seasons permits uninterrupted breeding of the anophelines. This naturally determines the number of broods per year. In the tropics there may be 15 broods hatched per year, while in our latitude there may be but four and at the arctic circle, but one. These prevailing

climatic factors make a tremendous difference in the average annual mosquito population.

Moreover, the climate determines the life—the survival time after infection, during which the mosquito may infect.

The sexual phase of the malaria parasite in the mosquito is completely inhibited below 61° F.; at 68 to 70° F., 18 to 19 days are required to complete the cycle, while only 8 to 9 days are required when the thermometer is in the eighties.

This all means that when a reservoir is available there are more mosquitoes, infective sooner and living longer; a combination that contributes to a high endemic malaria rate.

THE LIFE CYCLE

In both yellow fever and malaria, the life cycle of the specific organism is relatively simple—a vector, the mosquito, serving as the go-between from the reservoir to man. The specific organism must in either case go through a single developmental phase in the vector.

Frequently the life cycle of a parasite is more complicated and the more interesting. In the life cycle of the Schistosome, from man to man, the parasite must pass through several metamorphosis; one of these changes takes place in water, the balance in a specific species of snail. From the snail emerges a free swimming cercaria which seeks out man, if he is in the water, and penetrates his skin. Without a susceptible gastropod host the life cycle of the parasite is broken.

In the case of the liver fluke, Clonorchis Sinensis, an even more complicated life cycle prevails. In this disease, man and domestic animals are the definitive host or reservoir. The cycle from man to man requires two intermediate hosts, a suitable species of snail and a fresh water fish. In each of these hosts, the parasite must undergo a specific metamorphosis. Man acquires the disease by eating insufficiently cooked fish, the second host. The absence of either intermediate hosts breaks the life cycle and the parasites perish.

From the foregoing, we may assume that the simpler the life cycle of the specific organisms, the more prevalent the disease is likely to be.

THE RANGE OF VECTORS

Other determining factors in the prevalence of most tropical diseases are the range and the behavior of their vectors. It is perfectly obvious that a mosquito-borne disease will have wider distribution and higher prevalence than a disease such as Clonorchis Sinensis which has intermediate hosts that are limited by the waters of a stream. In mosquito-borne diseases we are dealing with an insect with a wide range of dispersion and which seeks out man for a blood meal necessary to mature its eggs. In Clonorchis Sinensis we are dealing with two intermediate vectors that have a narrow range of activity, do not seek out man—man goes to them—and neither vector requires man for its existence.

Geographic factors may determine the distribution of some diseases through their influence upon their vectors. Bartonellosis (Oroya Fever) is endemic in certain deep valleys of the Andes mountains. Other nearby valleys remain free of the disease. The altitude of the mountains serves as a barrier both physical and climatic, obstructing human communication and the dispersion of the Phlebotomus sand-fly, the vector of the specific organism of the disease.

Thus, we see that climate and biology themselves are two important factors that determine why most so-called tropical diseases tend to remain confined to the tropics.

CULTURE OF THE PEOPLE

Apart from the specific organisms and their vectors, I have always been interested in the manner in which people live in the tropics. The manner of living is often the determining factor in whether people acquire a given disease. We might call manner of living, standard of living.

To some, a high standard of living means, automobiles, juke boxes, gadgets that can be bought. To me, it means among other things, modern plumbing, concrete, screens, miscroscopes. Through these, and many more, we have erected various barriers against communicable diseases.

In the development of this country we have passed through a series of steps from a primitive pioneer existence only slightly above the savage that preceded us. This pioneer phase, in which men lived very close to nature, gave way to an agricultural stage and this in turn has gradually merged into our present day industrial phase. Europe has followed much the same course. The transition has been a gradual one and during that time we have seen many changes in the prevalence of communicable diseases. After the era in which every back yard had its shallow well and near-by privy, cholera retreated to the tropics where it still remains endemic. So has leprosy. Plague as an epidemic disease had done the same. Yellow fever to us here is no more a threat. Malaria which was highly endemic in the early days of the Ohio Valley has been gradually retreating further and further south.

During the transition we have erected certain barriers between ourselves and pathogenic organisms. Often the barrier operates against the vectors of disease.

We take our present manner of living too much for granted. We first acquired a back yard privy, which was better than no privy at all. Then we

replaced the privy by an indoor toilet with plumbing.

In addition to helping us free ourselves of epidemics of intestinal diseases, plumbing has made it possible to be clean easily. A bath is no longer an ordeal to be dreaded—an unpleasant adventure in which on Saturday night the whole family took their part carrying water, heating it on the kitchen stove, each waiting his shivering turn with a chunk of coarse yellow soap, a poor product of home industry. With the aid of the commercial steam laundry, and the dry cleaner, we have become one of the few animals free of lice; and incidently of typhus fever. Typhus has retreated to those regions where men still can't take baths and change their clothes.

Times and circumstances no longer condemn us to live 15 to a room in a thatched hut with dirt floors. Under these conditions men lived in intimate contact with domestic animals and rodents, with their lice, fleas, feces and parasites.

Our houses have acquired space, a roof that won't leak, a floor, glass windows and screens. We no longer share our bedroom with the family sow and walk in her droppings with our bare feet. Our houses at last are being built vermin and rat proof. The bed bug, the mosquito, the housefly, and the cockroach, all vectors, we no longer tolerate. We have put numerous obstacles between ourselves and disease.

The tropics have not kept pace with us. Today countless millions live in conditions incredibly bad —often worse than savages—in filth, ridden with parasites and vector borne diseases—primitive conditions of living that we long ago abandoned. We have demonstrated that we can transport our manner of living to the tropics, adapt it, and can live with safety even in the most insalubrious spots.

A CONTRAST IN LIVING

Last summer in Central America I had the opportunity to compare two racial groups living in the same climate and environment. The state of health of these two groups presented a contrast that was amazing. Although in the same region, the two groups have not mixed either socially or sexually. One group was native Indian, the other pure negro. The negroes are called Caribs.

The Caribs have an interesting history. In 1779 they were deported by the British from the Island of St. Vincent to the Eastern Coast of Central America. In St. Vincent they had revolted against the British rule. Legend and some authorties have it that the Caribs came to this hemisphere from Africa before Columbus. Certainly, their language and their customs have remained African to this date.

The difference in their health is explainable largely by their manner of living. The Indians are ridden with malaria and all other parasitic diseases of the region; the Caribs are robust, rarely ill, rarely hospitalized.

The Indians live in or on the fringe of the jungle. Here abundant standing water produces a large mosquito population. Chickens and dogs, turkeys and hogs have free run of their manaca palm shacks. The family, barefoot, tracks constantly through feces, dried, sometimes not so dry; barnyard feces, often human, too—since the disposal of excrements is often left to the chickens and the hogs, in lieu of the privy. Hookworm infestation is nearly 100 per cent.

The Indians are scattered over the countryside. They build their shack with little concern for a safe water source. Usually this is of the roof-rain-barrel type which provides ideal breeding for aedes and anopheline larvae. Their shacks made of palm fronds, though a protection against the weather, are an invitation to a mosquito to come in out of the rain. Their food is monotonous —ill prepared, often revolting. Among them amebiasis is abundant.

The Caribs, on the other hand, live in a compact village which is a well organized community, under the leadership of a "chief". Their tribal laws and customs derive from Africa. Their village sites are always on the sandy sea shores beneath the cocoanut palms. Here natural drainage is excellent, there is no standing water for mosquito breeding and strong prevailing sea breezes block the invasion of their village by mosquitoes bred in jungle ponds.

Tribal customs demand bathing in the surf. Their excrements are deposited in pottery jars and carried to the sea. Their village site is spotless, clean; no refuse; their palm shacks are the same. All domestic animals are kept beyond the confines of the village—a communal project. They sail the coastal waters in large dugout canoes and fish is an important part of their diet. They make and sell copra. They cultivate yucca and this, made into thin cakes, is crisp and delicious. Their wells dug in sandy soil, fenced off to prevent pollution, provide an abundant and reasonably safe source of water.

Through the application of a simple code of hygiene, these Caribs live in a manner in which morbidity from the prevailing diseases is reduced to a minimum. This manner of living, certainly not a high standard of living, serves to put certain effective barriers between them and the local endemic diseases.

ARE WE IN DANGER

We have been warned that we are to see tropical diseases return with our soldiers. Some of these warnings have even suggested epidemics and many laymen visualize such vistations as the great "black plague".

It is true that our soldiers are in every quarter of the globe and are exposed to the diseases of those places. Already many have returned and some are being mustered out of service. These men are to return to every nook and corner of the United States. The diseases that they bring back will certainly be widely distributed.

With the foregoing general knowledge of the behavior of tropical diseases what may we actually anticipate? There is little doubt that we may expect a variety of tropical diseases widely distributed. Many of these cases will be unrecognized or incorrectly diagnosed because we have not been accustomed to tropical medicine.

Efforts are already under way to train clinical pathologists in methods of diagnosis and to train teachers in tropical medicine in the various medical colleges of the country where little emphasis has been placed upon tropical diseases.

These efforts are directed toward the recognition of the diseases in those who return with them and towards prevention of their spread to others at home. It is in the possibility of a spread of these diseases that we may indulge in a little speculation. Time permits only a brief consideration of the more important.

THE INTESTINAL GROUP

The bacillary dysenteries follow the man-feces-food-water-fly-man cycle of transmission. They tend to be acute and self-limited. They are a problem of troops in the field. We have had the bacillary dysenteries with us. They will not be much of a problem in civil life.

Amebiasis, following the same cycle of transmission, is endemic in the tropics. We have it, of course, in the United States and have become more aware of it following the Chicago episode. We can expect to see many cases. Most of those returning home will be in the subacute or chronic phase of the disease. Many will be overlooked, many called ulcerative colitis or something else without efforts made to make an accurate diagnosis. We are still seeing occasional cases traceable to Chicago, all these years without benefit of diagnosis. In its diagnosis do not forget that the immediate examination of material obtained from an actual lesion through the proctoscope is much superior to a specimen of feces, hours old, sent to a laboratory.

Cholera is a big menace in the Asiatic theatre of war. Troops destined for the Far East are receiving prophylactic vaccine. Cholera is still endemic in India. As late as 1911 its entry into the United States was blocked at the port of New York. Even should an occasional case pass our sanitary blockade, the present obstacles alone, modern plumbing, and controllled water and food supplies will make impossible such a disaster as we had here as late as 1873.

It is permissible to consider yellow fever and dengue together since they have several features in common. Both are acute febrile diseases with abrupt onset and are self-limited. Both are followed by a period of immunity, a prolonged one in yellow fever. Both are due to viruses; both have for their principal vector the aedes aegypti mosquito. Dengue circles the tropical belt, yellow fever is endemic in tropical South America and Africa, not in the Far East. The reasons for this are not fully understood. Should yellow fever appear in the Far East, through a combination of virus reservoir and the vector (already there), the result would be a major calamity.

We are naturally more concerned with the potentialities of yellow fever because of its high mortality. The mortality of dengue is negligible.

Our country has seen several severe epidemics of yellow fever in the past. It is unlikely that we will have them again. The reasons for this are threefold. First, the vector of urban epidemic yellow fever is well known and easily controlled. Second, all army personnel entering the yellow fever area are well protected by the relatively new and very effective yellow fever vaccine. And, third, the endemic areas of South America are under rigid control by machinery already set up and efficiently operating even before the war. In Africa the same machinery is being set up. Thus far, actual war has not touched the areas of endemic yellow fever to disrupt this control machinery. But the threat always exists where the aedes aegypti mosquito is found.

WORMS

We can easily dispose of diseases due to helminths (worms). Most of these follow a cycle of transmission that geography and biology sharply limit. Many of the parasites, requiring intermediate hosts for development, will not find these hosts available here.

Of the group of helminth diseases, the more important are schistosomiasis and filariasis.

Schistosomiasis is produced by three principal varieties of blood fluke. Taken together as a group they circle the equatorial belt. They all require a suitable gastropod intermediate host. This means that the opportunity for spread is very limited, depending on the availability of a suitable host and the added factor that an aquatic life limits the range of activity of that host.

Filariasis is widely distributed in the tropics. There are several varieties and their intermediate host (vectors) are insects which include some of the biting flies and mosquitoes. Only the mosquito vectors we need fear. This is a culex which is one of our own widely prevalent varities.

It is very unlikely that we will see many cases

in civilians traceable to returning solders. The reasons are several. It is not easy for an endemic focus to maintain itself in our climate. We did have such a focus in South Carolina. Clinical filariasis is slow to develop. It takes multiple infections to produce the deformities of the disease. It takes a relatively large human reservoir of microfilaria to infect an appreciable number of mosquitoes. It is presumed that our soldiers on returning to this country will be dispersed. This dispersal will operate as a factor against filariasis establishing itself. The time required in the mosquito for the microfilaria to become infective for a man is sufficiently long in this climate that the natural mortality (always high) eliminates the most of the infective mosquitoes. And moreover, the general popularity of screens with us offers a barrier to infection that does not exist in endemic regions.

LEPROSY

Leprosy, endemic in the tropics where it finds a degree of human wretchedness suitable for its maintenance, will certainly not become a problem here after the war. It is a disease of low communicability and very long incubation period. Even though a few cases contracted in the tropics return, we have learned by experience that transmission to others will not take place in our climate. Leprosy, widely distributed in Europe in the middle ages, receded to the tropics as the standard of living improved, no other known factor operating.

Leishmaniasis will inevitably be acquired by some of our troops. There are several varieties of this chronic protozoan disease. Its vector is the phlebotomus sand fly. Here where the vector does not exist the problem will be not of transmission but of diagnosis. This falls to the clinical pathologist and his smears, cultures, and biopsies.

PLAGUE

Plague, Pasteurella Pestis to the bacteriologist, a disease of rodents, is intimately associated with the rat. We acquire the disease through his flea, a vector, and by direct contact, when the pneumonic form of the disease prevails. Whenever man lives close to the rat, there we will find the plague. Such close association is to be found in the tropics where humans and rats inhabit the same hovel. The distance between rat and man is literally one jump of a flea.

All rats prefer to depend upon man's bounty or carelessness for food. Plague is closely related to variations in the rat population, rat migrations, and natural phenomena such as floods and famines. The geographic distribution of the disease also depends on rat species. There are several varieties of rat. The more important are the smaller English house rat, the Alexandrian roof rat, and the larger more pugnacious Norwegian rat. The former two are more domesticated, if we may use the word, and live closer to man. The latter is more wild and lives apart from man. In a contest between the two, Rattus Norvegicus comes off best. Where he dominates the scene, plague is less likely to be found than when the other species prevail.

Human plague is usually an acute illness with abrupt onset and a high mortality. Clinical plague is not likely to be among troops returning to the United States. Actually, plague is nothing new to us. It has been endemic as an epizootic disease in our Western states among wild rodents—squirrels, rabbits, and the prairie dog. A few humans have acquired the disease from them. Unlike the rat, these animals avoid man rather than seek him out. Experience of the past years has shown that unless something unforeseen takes place, the barriers that we have placed between ourselves and the rat and his flea will continue to be effective in preventing epidemic human plague.

TYPHUS

Typhus always has been a disease of armies. It is now listed as a disease of "special military importance". A glance at the epidemiologic map will suffice to show that typhus fever is a disease of the north rather than of the tropics. In the tropics, because men can wear less clothes and bathe easily, lice are uncommon; so is epidemic typhus, though the more mild flea-borne variety is often seen.

Epidemic typhus is a disease of men who stay lousy because they can not change their clothes and take a bath. Lousiness has always been widespread in Poland, the Balkans, and West Russia. We, not in the military, do know the part that it has played in the Russo-German struggle. It has appeared in Spain and Naples and reports coming out of Europe would indicate that it has been a serious problem.

Perusal of the column "Public Health Under Hitler" of *The Journal of the American Medical Association* contains frequent allusions to delousing, public typhus education, new sanitary regulations, inoculations. The implications are that the Nazis are fighting typhus. It is to their credit that it has not become a conflagration. Their efforts to control it have been dictated not by humanitarianism, but by self-protection.

In occupied Europe there exists all the conditions which favor lousiness and lousiness means typhus. These factors are the filth of battle

itself, and among civilians the widespread bombing which has interrupted public services—gas, electricity, water, steam laundries, dry cleaning and the soap supply. Added to this is the mass migration of lousy and infected individuals into these areas.

The Army, realizing the threat of epidemic typhus, has taken steps to protect personnel sent to the European theatre of war. Every soldier receives the new Rickettsia vaccine. This vaccine apparently does not posses the effectiveness of yellow fever vaccine or typhoid vaccine, but it is none-the-less an important weapon in minimizing both mortality and morbidity. Experience with it will provide the data necessary to fully evaluate it.

Since epidemic typhus follows the man-louse-man cycle of transmission and does not follow the rat-flea-man routine of the endemic variety, even the anti-louse measures of World War I were effective in preventing typhus on the Western Front. Now we have even better anti-louse procedures. Chemical delousing such as by methyl bromide has been made simple and practical. The new wonder powder D.D.T. both kills and prevents lice. A burst of the powder up each pant-leg, sleeve and down the neck, without undressing, requires a few seconds and will louse-proof clothes for at least a month. It is even better if the clothes are not removed.

These methods now proving effective where the disease exists will certainly smother the disease before it starts here where we have all the other means for keeping clean. We should not forget the habits of the louse and an examination of the clothing may be more help sometimes in making a diagnosis than an examination of the patient.

MALARIA

Malaria is a number one health problem in both the Army and the world. More persons are living with and dying of malaria than any other disease.

Already we are seeing many cases in returned soldiers. Most of these cases are and will continue to be the tertian variety, notorious for its high relapse rate. In the foregoing paragraphs we have indicated some of the biology of malaria.

It has been so infrequent here that many of us have never seen a case. It is highly probable that nearly all of us will have that opportunity in the next few years, since large numbers of men will return from hyperendemic malaria areas Some of these will represent relapses; others, malaria developing weeks after suppressive atabrine.

It is inevitable that we will also see many cases among civilians traceable to these men The debate between malariologists is not the above, but whether we shall again have malaria endemic in our north which has been practically free of it for many years. This is not an impossibility.

In the United States we have several varieties of the Anopheline vector. Of these the Quadrimaculatus is the most important, since other varieties are more zoophilic in their habits. Factors that have operated in the past to reduce malaria will continue to operate in the future. Some of these are our change over from a rural to an urban type of life, the reduction of standing water sites through destruction of the water shed and cultivation of land and our general demand for screens, even for the most humble cottage.

In comparatively few places in the north have we instituted any planned mosquito control. Some of these in the south have produced excellent results. It is entirely possible that we will have this forced upon us. That is a problem for public health and sanitary engineering departments.

We as physicians can contribute much to prevent the establishment of new endemic foci by promptly recognizing malaria and treating it adequately. Every case of malaria that I have seen thus far in returned soldiers has been a relapse and in most instances the story has indicated inadequate treatment. Old-timers in the tropics tell you that number of days is more important than grains per day. Both should be adequate. One important reason for hyperendemicity in tropical countries is self-medication—the belief that the criterion of a cure is the cessation of fever—treatment never adequate to rid the circulation of gametes.

We may have to include in our routine blood count, a search of the smear for plasmodia—certainly for returned military personnel. Laboratory technicians whose only acquaintance with malaria has been a slide demonstration will have to acquire proficiency in identifying the many forms of the various malaria parasites. They must learn the thick drop method so useful for a quick diagnosis. In some cases a diagnosis is urgent. Even pathologists will have to acquire a new knowledge of the histopathology of malaria.

We must learn that a large number of malaria patients do not present the classic periodic chills and fever. We must not forget that malaria can imitate any thing from meningitis to dysentery that in an apparently healthy person an even trivial incident can precipitate a relapse. We have to adopt the habit of those who live in the tropics to suspect malaria in every patient presenting fever (certainly for returned soldiers) until we prove it something else. But we must not neglect to prove it.

Progress in Neurosurgical Treatment of War Wounds

W. JAMES GARDNER, M.D.

THE medical officer in this war has in his hands three new and powerful weapons in the battle to save human lives. These are blood plasma, sulfonamides and penicillin. Through the use of blood plasma patients are rescued from traumatic shock, many of whom would not survive if treatment had to be delayed until the more cumbersome method of whole blood transfusion could be employed. Sulfonamides applied locally, given by mouth, or parenterally have reduced infection to the point where it is a nuisance rather than a severe threat to the patient's life, and the evidence indicates that penicillin will work even a greater miracle in the control of infection.

These three advances in the treatment of war wounds are mentioned only in passing since they apply to wounds of all types. The purpose of this paper is to consider specifically the advances in treatment of wounds of the nervous system. However, because of plasma, sulfonamides, and penicillin a much higher percentage of patients with brain wounds as well as wounds involving the peripheral nervous system are going to survive so that definitive treatment can be applied.

BRAIN WOUNDS

Let us first consider brain wounds. With the exception of the use of blood plasma, sulfonamides, and penicillin craniocerebral wounds are treated much the same in this war as in the previous war. They constitute an exception to the general rule that primary closure shall not be attempted in a gunshot wound. Primary closure, of course, is essential in every brain wound. Otherwise, the patient is almost certain to die of a resulting meningitis and cerebritis. The treatment, therefore, is thorough débridement and closure. This is all that is attempted at the first operation. Naturally, with the use of sulfonamides and penicillin the percentage of cases of meningitis and of secondary brain abscess is very greatly reduced.

The repair of the resulting cranial defect has been greatly advanced by the development of a new material for cranioplasty. This material is tantalum. Tantalum is a pure metal which is the 73rd element in the periodic series, occurring in group V. It is manufactured in thin sheets which are six inches square. It has two advantages which render it almost ideal for covering cranial defects. The first is that it is biologically inert and will heal in the tissues of the host by a process of encapsulation with practically no evidence of irritation. The second advantage of tantalum is that sheets of this metal twelve and one-half thousands of an inch in thickness are sufficiently firm to afford adequate protection over a cranial defect of any size, and yet it is sufficiently soft and ductile so that it can be cut at the operating table with an ordinary pair of heavy scissors and can readily be bent into proper shape by pounding with a round-headed hammer.

Carney[1] and Burke[2] demonstrated experimentally the tolerance of the animal host to tantalum. Pudenz[3] in 1942 demonstrated that hemostatic clips made of tantalum caused virtually no reaction in the surrounding brain as compared with similar clips made of silver. Pudenz and Odom[4] showed that a thin film of tantalum foil placed on the intact or wounded cortex of the brain excited less reaction than any of the other materials which they tested. Pudenz[5] in 1943 demonstrated experimentally the advantages of tantalum as a material for closing cranial defects, and Fulcher[6] was the first to report the use of this material in repairing a cranial defect in man. Since then the use of tantalum has become increasingly popular with neurological surgeons for the closure of cranial defects. The simplest method of using this material is as follows:

A sheet of tantalum along with the necessary tools for cutting and shaping it is sterilized along with the other surgical instruments. The scalp is reflected so as to uncover the cranial defect. A piece of tantalum is cut by means of tin shears to a size that will completely overlap the edges of the cranial defect. It is then placed on a concave wooden block and pounded with a round-headed hammer until it conforms to the

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The opinions or assertions contained herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at Large.

contour of the skull. The implant is then laid over the cranial defect on the outer table of the skull and the scalp is closed over it.

If the implant is not fixed to the skull, there is a possibility that it may slip sideways so that part of the cranial defect is exposed. Furthermore, during the early convalescence the pulsation of the brain may cause a movement in the implant so that it causes a clicking sound against the skull, which is rather annoying to the patient. For this reason, various methods of fastening the implant to the skull have been devised. Some surgeous prefer to cut a groove in the outer table of the skull into which the implant fits snugly. Others fasten it by means of tantalum wire sutures which are passed through holes drilled in the skull. The most satisfactory method, however, is to fasten the implant to the outer table of the skull by means of small tantalum screws. Unfortunately proper size tantalum screws are not yet available on the market, and screws made of other metals should not be used because of electrolytic processes which may be set up.

In my hands the use of tantalum has proven so satisfactory that I have employed it to repair the defect in two cases of fresh compound fractures of the skull. Immediate tantalum cranioplasty will reduce morbidity in brain wounds for the following reasons: It immobilizes and protects the traumatized brain and scalp during the healing process. It prevents adhesions from forming between the brain and scalp. It reduces the incidence of cerebral fungus and post-traumatic epilepsy. It prevents the progressive brain atrophy which occurs beneath a cranial defect as a result of the constant pulsation. It eliminates the need for a secondary cranioplasty. It seems very likely that tantalum will soon be in use in many front line hospitals so that cranial defects may be repaired at the time of the initial débridement.

SUBDURAL HEMOTOMA DUE TO BLAST INJURIES

In February of 1942, Abbott, Due, and Nosik[7] described the clinical picture and operative treatment of subdural hematoma and effusion as the result of blast injury. From their experience at the U. S. Naval Hospital at Oakland, California, where they received casualties from the South Pacific, they concluded that a subdural hematoma or effusion could result from a blast injury even when there is no direct trauma to the head. The patients usually presented a history of exposure to severe blast, loss of consciousness for a period varying from a few minutes to several days, persistent headache, loss of memory, and irritability. The neurological findings were usually vague and changing. The diagnosis could be confirmed by encephalography, and the treatment was trephination and drainage of the subdural space. It is possible that there are a great many of these cases being discharged to civilian life with the diagnosis of psychoneurosis.

EARLY MOBILIZATION OF CASES OF HEAD INJURY

In December of 1943, MacKenzie[8] advanced the hypothesis that the post-traumatic syndrome of dizziness, light-headedness, blackouts, headaches, mental and physical fatigue in at least some patients is due to an injured and, therefore, unstable vasomotor system incapable of quickly supplying blood to the brain, when the position is suddenly changed.

He believes that many of these cases are brought on or aggravated by prolonged bedrest following head injury. During the period of bedrest, the injured vasomotor system adjusts itself to supplying blood to the brain in adequate amounts only in the horizontal position. When the patient assumes the erect posture, a train of symptoms will ensue. In order to prevent this train of symptoms from developing, McKenzie advises early mobilization of the patient with an injured brain. The patient should be made to get up when he prefers to lie in his bed, to shave himself, and then gradually be persuaded to go to the department of occupational therapy. Dr. McKenzie believes it is far easier to prevent this syndrome from developing than to cure it after it has developed.

Hemostasis has always been a problem in neurological surgery. Two recent contributions point the way to a partial solution of this problem. Putnam's[9] method is to apply soluble cotton pledgets saturated with liquid thrombin solution to the bleeding point and leave them in place. The oxydized cotton is absorbed over a period of days leaving some tissue reaction, but it does not cause adhesions between the dura and brain.

Ingraham and Bailey[10] solved the problem of hemostatis in brain surgery by applying the thrombin solution on some human fibrinogen in the dry state. The fibrinogen was applied to the bleeding point with gentle pressure and left in place. This was found to be very effective in hemostatis and non-irritating.

Ingraham and Bailey also advocate the use of fibrin film as a substitute for human dura, and they have used it to close traumatic and operative defects in order to prevent meningocerebral adhesions. These fibrin films are composed of plasma proteins; they are translucent, flexible, and sufficiently tough so that they can be sutured in place. Their experiments indicate that they cause little cellular reaction and are eventually replaced by a new membrane of fibrous tissue which does not adhere to the previously traumatized cortex.

A promising method of repairing wounded nerves is the newly described "nerve glue" technic. This was first described by Young and

Medawar[11] in their experiments on rabbits. The method consists simply in holding the cut ends of the nerves together and pouring around them cockerel plasma which has been mixed with a little strong tissue extract. In about one-half to two minutes the plasma clots to a firm jelly which holds the stumps together.

Tarlov and Benjamin[12] repeated this work and found evidence of an inflammatory reaction, and they, therefore, suggested the use of autologous plasma, which they found to give less tissue reaction in rabbits than did cockerel plasma. They felt that the union obtained by the use of "fibrin suture" was equal to that obtained with silk suture except where there was tension at the suture line since the fibrin clot had less holding power than the silk.

Seddon and Medawar[13] also used "fibrin suture" on human nerves. They found it to be of great technical value for use in suitable cases because of its speed and simplicity. They recommended it particularly for primary suture when there was no tension on the suture line and especially for nerve grafts. For secondary suture they used it only when there was no tension at the suture line and no great disparity in size of the resected surfaces.

Spurling[14] has recently described the use of tantalum wire as a material for nerve suture. He uses a very fine wire three thousandths and five thousandths of an inch in diameter, and he presents gross and histological evidence that tantalum is inert in the human tissues. Because of the absence of foreign body reaction, one can anticipate a higher percentage of successful nerve anastomoses if this material is used. Spurling also advocates the placement of a cuff of tantalum foil about the site of the anastomosis in order to protect the area of the anastomosis from the ingrowth of fibrous tissue until regeneration is complete. Since the sutures and the enveloping cuff of tantalum foil can be visualized on the X-ray film, progressive X-ray studies of their position are of value in determining whether the anastomosis is still intact and whether a neuroma is forming at the site of anastomosis.

In October of 1943, Klemme, Woolsey, and DeRezinde[15] described three cases in which they bridged gaps in the peripheral nerves in the human being with a preserved cadaver nerve graft. The graft, after removal from the cadaver was preserved in formalin and then subsequently transferred to alcohol and then immediately before operation washed in saline. In these three cases the graft was fastened in place with acacia glue, which was simply 50 per cent acacia prepared by slowly dissolving it in boiling distilled water. The first patient who was treated with the application of a cadaver graft using 50 per cent acacia to glue the severed ends together is reported to have a good clinical result with return of motor and sensory function. The second patient is already beginning to get some return of function, and the third case is too recent to judge.

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Extent of Malnutrition

The American soldier, sailor and marine may be considered as extremely well nourished after he has been in the service for several months, even though he may have been suffering from one or more deficiences at the time of induction. The diet furnished and consumed by these men and women not only is adequate but may be considered far above average. As long as this diet is available and the individiual is able to ingest it, nutritional deficiencies do not occur. In the absence of injury or illness, malnutrition develops only when the soldier is separated from his source of supply and must live on an inadequate ration. The solution to this problem is the provision of a diet so light and compact that the soldier can carry it himself but of such high quality that, despite its restricted quantity, it will produce the least physiologic impairment. This problem, which has not been solved entirely, will be discussed later under the heading of priority of dietary essentials.—Com. on Convalescence and Rehabilitation, Natl. Research Council. War Medicine, Vol. 6, No. 1, July, 1944.

Diverticulitis of the Distal Colon

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COLONIC diverticulosis constitutes one of the most interesting and spectacular findings in the roentgen study of the colon. Diverticula are the commonest of all lesions found in the large bowel.

They are described as false hernial bulgings of mucosa and submucosa through a weak spot in the internal muscularis layer. They are never found in children, are rare before 40 and are common in middle-aged and elderly persons. The exact mechanism of their production is not understood. Most authorities agree that they are the intestinal counterpart of the pulsion diverticula seen in the esophagus. They may be present throughout the length of the colon in large or small numbers but their commonest site is the distal third, and more especially, the sigmoid. They occur in males in the ratio of two to one.

Since diverticulitis naturally develops in preexisting diverticula, the anatomical basis for their development merits a brief review. The external longitudinal muscle does not form a continuous sheath in the colon as it does in other parts of the intestinal tract. It is arranged in three longitudinal bands. Between these bands the intestinal wall is congenitally weaker than it is in the areas occupied by the bands. The entrance of blood vessels into the colon wall through the circular muscle coat alongside the longitudinal muscle further weakens the circular muscle. A further contributing factor may be the nature of the fecal mass, whether it is consistently firm or hard or whether it is normally soft and yielding. This factor undoubtedly plays a role in the development of inflammatory changes in diverticula.

HISTORY

Historically, interest in the presence of diverticula of the colon dates back to the days of Cruveihlier and Virchow in the years 1849 and 1853, respectively. In 1898, Graesser described the formation of diverticula of the intestine and pointed out the frequency with which they occur. Subsequently others made contributions but it was not until 1907 that the first series of American cases which were operated were reported out of the Mayo Clinic.

Diverticulosis, the term now commonly used to designate the presence of diverticula of the colon, is usually of no immediate clinical importance. They may give rise to several secondary processes but diverticulitis, in some form or other, is the most important. Colonic diverticulosis is easily demonstrable in the great majority of cases by roentgen methods. When barium enters the sacculations they appear as bud-like projections from the intestinal wall. If solidly filled, and the sacs project anteriorly or posteriorly, they may not be seen in profile and their presence can not be established until after the mass of barium has been evacuated. Even then diverticula may be hidden by smaller amounts of residual barium and it is unwise to make a negative diagnosis until the lumen of the bowel has been completely emptied, leaving the bud-like projections as the only reservoirs of barium.

X-RAY FINDINGS

Diverticula may be demonstrated either by the ingested barium meal or by barium enema. If there is any clinical evidence of disease of the colon the enema study should be done first. This materially lessens the danger of making a partial obstruction a complete one.

The instillation of the enema should be done under fluoroscopic control so that the contours and movements of the bowel can be studied from all angles. It is frequently desirable to take spot films on the fluoroscopic table as the column of the barium suspension progresses. For at times such films will show something which the completely filled colon will not show. Further, post-evacuation films are of great value and will often reveal diverticula which were not seen when the colon was full.

The reasons for diverticula not filling immediately are presumed to be (1) swelling of the mouth of the diverticulum or (2) the diverticulum may be filled with bowel contents which do not permit barium to enter. In the latter in-

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stance it is assumed that peristaltic activity of the bowel empties the fecal material following which the barium may enter.

ENTEROSPASM

There is a group of cases classified as diverticulitis with enterospasm, which presents a characteristic radiological appearance which should not be confused with any other lesions of the colon. On fluoroscopic examination these cases present a degree of spasm which may be slight or marked and which is persistent. The spasm may be so marked as to cause intermittent obstruction to the flow of the injecta. During the administration of the enema the patient may complain of pain in the left lower quadrant. The diverticula may be seen fluoroscopically or in films made subsequently. No mass is felt at this stage though in thin subjects one may be able to palpate the sigmoid colon. Definite tenderness over this bowel segment is usually readily demonstrable. The bowel pattern in such instances has a saw-tooth arrangement with the teeth arranged more or less regularly and fairly close together due to spasm of the circular fibers.

Even if one is unable to demonstrate diverticula in the involved area, should there be diverticula in other segments of the bowel, it almost necessarily follows that diverticula are present in the sigmoid area since this is the usual nature and distribution of the abnormalities. In the majority of cases seen at this stage the inflammatory reaction subsides under proper management.

It is interesting at this point to note that a number of our patients who have diverticulosis of the colon who have had definite discomfort in the left lower quadrant from time to time, have been benefited by the ingestion of barium sulphate in 1, 2 or 3 ounce doses for several days. This observation followed the improvement in several instances of symptoms of this nature after a diagnostic X-ray study had been made. Barium taken therapeutically in this manner can be seen subsequently to have lodged in the diverticula and it is assumed that the barium, although chemically inert in the alimentary tract, has a soothing effect on the walls of the divertidula where low-grade infection is present. Possibly this is due to the mechanical displacement of infected material which is replaced by less irritating material.

The next stage of diverticulitis is that with infiltration. In this stage the deformity of the sigmoid usually increases and changes in character from an inconstant filling defect due to spasm to a harder, more fixed appearance due to the presence of inflammatory cells and edema in the wall of the bowel. On fluoroscopic study partial obstruction to the enema flow and to its evacuation may be met. A tender mass may be felt in the left lower quadrant, which corresponds to the sigmoid defect. The saw-tooth deformity referred to above may become more irregular and the teeth become deeper and further apart.

Fewer diverticula may be seen at this point and they may, indeed, not be demonstrable. This phenomenon may be due to two factors, namely, the diverticula are filled with fecal matter and second, the ostia of the diverticula may have become sealed off due to edema of the mucous membrane. Diverticulitis with infiltration may thus usually be differentiated from diverticulitis with spasm by the presence of an indefinite tender mass which corresponds to the sigmoid defect, and by the deepening and widening of the serration in the bowel wall. The late cases in this second group must be differentiated from carcinoma.

Diverticulitis with perforation constitutes the smallest group of diverticulitis cases. In acute perforation most patients are operated upon as abdominal or pelvic emergencies without pre-operative X-ray investigation. We have had several instances in which such emergencies arose in persons whom we had had occasion to examine previously and in whom we had demonstrated diverticula. When the emergency arose, the diagnosis was comparatively simple! The signs and symptoms of these patients have been those of appendicitis, and the condition has been likened to it by referring to it as a "left-sided appendicitis".

The most common differential diagnosis we are called upon to make as radiologists is the differentiation between obstruction due to diverticulitis, and carcinoma. This differentation is sometimes easy, often difficult and less often impossible. The pain associated with the diverticulitis case with obstruction is usually more severe, apparently due to muscle spasm of the intestine. The patient may be covered with perspiration and may be in varying degrees of shock. The presence of fever and leukocytosis may be of aid. There may be a history of previous attacks, however mild. Careful history is of inestimable value. In obstruction due to carcinoma of the sigmoid, there is usually a history of continuous and slowly increasing disability. Blood may have been noticed in the stool which is seldom seen in diverticulitis. Fever and leukocytosis are absent unless there is a complication.

DIFFERENTIAL DIAGNOSIS

The roentgenological differential diagnosis can not be made, of course, unless some of the opaque material can enter the constricted area. If even a tiny amount of opaque suspension can be gotten through the obstructed area the differential diagnosis depends on two important observations: (1) carcinoma destroys the mucosa and

(2) it produces a margin on which no mucosal pattern can be seen, while in diverticulitis the mucosal folds persist and are usually exaggerated. The malignant constriction remains unchanged in size and shape while the inflammatory constriction may vary from time to time in its more intimate detail.

Serial radiographs are of great help in making these observations. Of less importance is the fact that a malignant constriction is usually relatively short and the walls adjacent to it usually fill out widely and flexibly. In diverticulitis the constriction is usually relatively longer and the adjacent gut is likely to be irritable.

The demonstration of diverticula per se does not necessarily rule out carcinoma. The incidence of diverticulitis and carcinoma occuring in the same individual is rare. Rankin reported 227 cases of diverticulitis with only 4 carcinomas, and in another series of 679 carcinomas of the colon only 4 cases of diverticulosis were found. Somewhere we have read that it would almost appear that having diverticulosis was good insurance against carcinoma. In some of Rankin's cases the diverticula were found to be separated by some little distance from the carcinoma so that the concurrent findings were merely coincidence and in no way related. No less an authority than Ross Golden has summarized the situation as follows: "we may with reasonable assurance dismiss from our minds the possibility that diverticulosis bears a causative relationship to malignant disease".

Close collaboration between radiologist and surgeon in these cases of obstruction is absolutely essential. Naturally, the first inclination is to operate and relieve an organic obstruction, even though it is not quite complete. We have gone along with the surgeon in his almost hourly observations and have repeated enema studies within a few hours. In diverticulitis cases we have found a changing picture so that such patients have been spared the necessity of operation.

One such instance occurred recently in which the patient, a woman, age about 45, was almost completely obstructed over a period of some hours. Careful management soon brought about a definite improvement in her symptoms and the surgeon, who exhibited excellent surgical judgment, decided not to do a cecostomy. Subsequent events proved the excellence of his decision because this patient is now going about her daily duties, is very well and has not had to be operated. Enema studies show an almost normal bowel lumen and the diverticula are again demonstrable, indicating that all inflammation has subsided.

Another type of patient is that in which complete obstruction is present. Such persons must have the benefit of cecostomy. We have seen instances in which such patients were not again examined roentgenologically but the abdomen opened after the cecostomy had performed its function, only to find that the mass was inflammatory and almost impossible of clean resection. Had enema studies been made in these cases, either per rectum or through the cecostomy, or both, a correct diagnosis might have been made. In persons who have had the benefit of the interim study, and who have been found to have diverticulitis, the cecostomy has been left open for months while the pelvic mass and obstruction subsided.

The last person in this group of our cases had the cecostomy for five months, has now been closed for a year and has been perfectly well. She was an extremely obese woman who was not a good surgical risk to begin with and in whom surgery of the sigmoid would have been most difficult indeed.

We agree with most observers that once the patient has had relief from complete obstruction by cecostomy, no great haste is necessary should the obstruction be due to carcinoma. If the growth is already large enough to have caused an obstruction, a few weeks delay will not jeopardize the patient's position further. Innumerable good surgeons have not been able to differentiate at the operating table between new growth and inflammatory mass. This makes it doubly important to have a pre-operative diagnosis if at all possible and no effort should be spared to make one if the opportunity is afforded.

Masked Hypoglycemia

There are probably many cases of spontaneous hypoglycemia in our practices and in our clinics masquerading as epilepsy, psychoneurosis, neurasthenia, menopausal neurosis, etc. The diagnosis in these patients can be established by a relatively simple and common laboratory procedure if care is taken to insist upon a normal diet preceding the tolerance test and to insist upon a five-hour examination rather than the conventional three-hour test. Complete medical study of a patient must be done as well as the glucose tolerance test. After the diagnosis is established, many of these patients respond to a simple dietary régime and appropriate treatment of the attendant disease, if any. Failure to respond calls for further study and diagnostic research by the physician.—W. Wallace Dyer, M.D., Philadelphia, Pa. The Pennsylvania Medical Journal, Vol. 47, No. 12, Sept., 1944.

Vertigo: Practical Considerations

PAUL M. MOORE, M.D.

THE problem of vertigo still remains very confusing. Classical vestibular vertigo with apparent rotation of external objects, nausea and vomiting, tinnitus and deafness can be readily recognized. This type may properly be called Ménière's syndrome. Even though the diagnosis is clear-cut, the possibilities for treatment are extremely varied.

What shall be done for the patient who complains of dizziness of lesser degree? This type of dizziness lacks one or more of the characteristics of true vertigo. It is a sensation which the patient experiences, giving no outward signs which the physician can see and measure. It is often a nebulous feeling of disorientation, which the patient himself is unable to describe accurately. A careful history is extremely important in order that the true nature of the complaint may be understood.

The first step is to determine what the patient means by "dizziness". It is important for the otolaryngologist to establish whether the dizziness is of the type which may be caused by a disturbance of the ear and its central connections or of the type which must be due to some other cause. This differentiation is not always easy, for the average person is a notoriously poor observer. He frequently takes refuge in vague and more or less meaningless terminology. Because of this, it is often necessary to question him specifically on each point.

THE HISTORY

Is dizziness associated with apparent rotation of external objects? If so, the dizziness unquestionably has its origin in the vestibular mechanism, either in the peripheral labyrinth or in the central connections. Vestibular nystagmus with its quick and slow components produces apparent motion of objects in direction of the quick component. I used to agree with the purists who believed that absence of this phenomenon precluded a lesion of the vestibular mechanism. Then one day I asked a patient in the midst of a caloric reaction, when the nystagmus was of second degree intensity, if the room appeared to be moving. His answer was "No". Apparently he was so involved with inward sensations that he paid no attention to his surroundings. This experience suggested the possibility that many patients may fail to observe this phenomenon during an attack of true vestibular vertigo. In mild attacks it may be absent even in patients who experience it in more severe attacks.

Is there nausea and vomiting? This is usually present in severe vestibular vertigo but may be absent in the milder forms. It may also accompany ocular vertigo. In acute digestive upsets with nausea and vomiting there may be a sensation of dizziness of the fainting type, which is the result of blood rushing to the abdominal cavity and producing cerebral anemia. In this state there may also be a buzzing or humming sound in the ears.

Are tinnitus and deafness present? These symptoms are always found in well-advanced cases of Ménière's syndrome and may involve one or both ears. When both ears are involved, the deafness is usually more pronounced in one of them. Both symptoms may vary with the attacks and intervals of remission. Tinnitus is often louder when vertigo is present. The deafness may become gradually worse preceding an attack and improve immediately afterwards. This is ascribed by Lermoyez[1] to a spasm of the internal auditory artery.

If the dizziness is not of the vestibular type, the presence of tinnitus and deafness does not change its classification, for they may be due to separate conditions. On the other hand, deafness may be absent in a case which may otherwise exhibit all the characteristics of vestibular vertigo. These vestibular disturbances are probably due to toxemia such as that caused by overuse of tobacco or alcohol or a definite focus of infection.

Is the dizziness constant or recurrent? True vestibular vertigo originating in the peripheral labyrinth is never constant except in the acute form of limited duration resulting from hemorrhage into the labyrinth, embolus suddenly shutting off the blood supply, fracture through the

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labyrinth, or acute suppurative labyrinthitis. In these conditions the vertigo has a sudden onset and is constant but of diminishing severity for a period of about two weeks. It has all of the characteristics of true vertigo, namely, rotation of external objects, nystagmus, tinnitus, deafness, and nausea and vomiting. If present constantly for a longer time this type of vertigo may be caused by an acoustic neuroma or other lesions affecting the eighth nerve in the cerebellopontine angle. In these lesions the vertigo is usually less severe. A similar vertigo without tinnitus and deafness may result from lesions affecting the central vestibular connections in the pons and cerebellum.

Dizziness lacking these characteristics and present over a period of months is not vestibular in origin. But do not allow the patient to mislead you. I have had patients who stated emphatically that they were dizzy all the time, and who with the next breath said they were not dizzy at the time of the interview. If the dizziness is really constant and not of the true vestibular type, the cause may be found in the cardiovascular system or the eyes. It may be due to an abnormally high or low blood pressure or may be the result of a general debilitating disease. True vestibular vertigo, i.e., apparent rotation of external objects, nausea, vomiting, and usually tinnitus and deafness, coming in irregularly recurring attacks with free periods between, is almost invariably due to a disturbance of the labyrinth itself. I say this advisedly because I have seen a few acoustic neuromas confirmed by pathologic examination which produced this picture. Atkinson mentions three such cases.[2] A very helpful diagnostic sign in acoustic neuroma is a diminished or absent corneal reflex on the involved side.

Is the dizziness produced by sudden change in the position of the head? Patients with arteriosclerosis experience a momentary dizziness on rising suddenly from a supine position. This is due to momentary cerebral and vestibular anemia. It seldom is associated with nausea or apparent rotation of external objects. During an attack of vertigo in true Ménière's syndrome the dizziness may be intensified by sudden change in position of the head. When the dizziness is comparatively mild and is present only when the head is turned suddenly to one side, it is most likely due to a closed eustachian tube. There is seldom any hearing loss in these patients, and tinnitus, nausea, vomiting and apparent rotation are usually absent. A feeling of being pushed off balance prompts the patient to reach for something to steady himself and is usually caused by turning toward the involved side.

Is the vertigo relieved by closing the eyes? If such is the case, it is an ocular vertigo. Vestibular vertigo is not relieved and in many cases is intensified by closing the eyes. Ocular vertigo should also be suspected when an attack follows going to a movie.

The length of time the disease has been present and the frequency and duration of the attack should be noted in the history.

EXAMINATION

If the history suggests that the vertigo is the vestibular type, even though some of the elements in the picture may be missing, a thorough ear, nose, and throat examination should be done. Hearing tests and inflation of the eustachian tubes should be carried out routinely in every case. An improperly functioning eustachian tube is usually the cause of the positional type of vertigo and sometimes the cause of the more severe Ménière's type. Caloric tests give little information in most of these cases but sometimes help to establish whether or not the induced vertigo is similar to the patient's attacks. Caloric tests should always be done on cases showing a unilateral lesion of the eighth nerve with a normal nerve on the opposite side, and always when a lesion of the central nervous system is suspected. The sinuses, tonsils, and teeth should be checked for possible foci of infection.

If the lesion is unilateral and especially if a central lesion is suspected, a careful neurological examination should be made and X-rays taken of the internal acoustic meatus. If these examinations are negative and the patient fails to respond to treatment, they should be repeated.

When a disturbance of the vestibular apparatus is not responsible for the dizziness, a thorough physical examination and eye examination are advised. Only too often the eyes are neglected in this problem. Ocular vertigo may or may not be severe. The most severe type occurs in acute ocular palsies, where the vertigo is incapacitating with nausea and vomiting. Less severe ocular vertigo produced by lesser degrees of muscle imbalance is rather constant and produces nausea but seldom vomiting. There is no rotation of external objects. The vertigo may become more pronounced after using the eyes over a prolonged period as is done in viewing a movie. One important finding is that the patient is always relieved by lying down and closing the eyes. Vertigo may also be caused by glasses in which the axis for the correction of astigmatism has been incorrectly made. Do not neglect to check the muscle balance and refractions in all cases which might possibly fall into these classifications.

TREATMENT

Ménière's Syndrome. Many varied treatments have been advocated and excellent results reported for each one by its respective outhor. There range from potassium chloride (Talbott and

Brown),[3] salt free diet and ammonium chloride (Furstenberg),[4] limitation of fluids and salts (Mygind and Dedering),[5] and exercises and baths to various operations on the labyrinth or the eighth nerve.

We have had our best results by using the treatment outlined by Harris and myself[6] in 1940 and by Atkinson[2] in 1941. This consists of 10 mg. of thiamin chloride twice daily after meals and 100 mg. or more of niacin three times daily after meals. The patient is also given a high vitamin diet.

Large doses of niacin should be used with caution because some patients may have a severe reaction to it. It must be taken with the last bite of food and never on an empty stomach or after a very light meal. The reaction, while not dangerous, is very uncomfortable and consists of a burning, tingling sensation and flushing especially of the neck and face. Atkinson advises modifying the dose, either increasing or diminishing it to fit the individual needs. Certainly it should be reduced if a reaction occurs when the patient has carefully followed instructions. This treatment helps the majority of patients.

There is a smaller group which Atkinson segregates by an intradermal test of 0.01 mg. of histamine dihydrochloride. After 5 minutes the normal person gets a wheal 1/3 to ½ inch in diameter with a surrounding flare of erythema 1¼ to 1½ inches in diameter. This reaction is considered negative. A reaction measuring more than this is positive and may show pseudopodia. Such a person should be desensitized with subcutaneous injections of histamine starting with 0.01 mg. of histamine dihydrochloride. Subsequent injections are given in gradually increasing doses at intervals of two to four days. The maximum dose may reach 1 mg. or less depending on the patient's tolerance. This is then repeated at intervals of four weeks. Six months later the course may be repeated.

Thus a patient with a definite Ménière's syndrome should first be tested for histamine sensitivity. If positive he receives subcutaneous desensitizing injections. If the reaction to the test for histamine sensitivity is negative, as the majority will be, the patient is given the thiamin chloride and niacin treatment.

In addition all definite foci of infection should be eradicated[7] and overuse of tobacco and alcohol stopped. The eustachian tubes should be inflated in every case,[8] and, if benefit results, the inflations should be repeated. Patients with a lesser ear disturbance from closed eustachian tubes, mainly the positional vertigo type, will respond to inflations. They also are helped to become stabilized by a short course of thiamin chloride and niacin.

When the dizziness is established as being due to an intracranial lesion, the patient is transferred to the neurologist or neurosurgeon for treatment. Likewise when its basis is a general disease, the internist takes over.

Ocular vertigos are treated according to their cause. In case of acute paralysis the affected eye is covered. In patients with muscle imbalance correction is obtained by muscle exercises and prisms.

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Surgical Approach to the Labyrinth in Ménière's Disease*

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A surgical approach to the labyrinth is reserved for those cases which do not respond to medical treatment and require elimination of the function of the labyrinth on the affected side in order to be free of sudden severe attacks of dizziness.

As you know, for some years the surgery has consisted of an occipital exposure of the brain which is elevated, the cisterna magna is drained, also the lateral sinus is drained, the dura opened and a portion of the eighth nerve sectioned which will include the greater part of the fibers passing to the labyrinth. This is an extensive surgical procedure and it does not always

*Discussion on paper presented by Paul M. Moore, M.D., Cleveland, before the Section on Eye, Ear, Nose, and Throat, Ninety-Eighth Annual Meeting of the Ohio State Medical Association, Columbus, May 2-4, 1944.

completely eliminate the impulses to the labyrinth unless the nerve is completely sectioned.

Since the purpose of the operation is to destroy the function of the labyrinth I have felt that a more direct attack on the labyrinth by an extracranial approach was in order.

It was demonstrated by Hallpike and Cairns in 1938 at postmortem performed on two patients who had suffered from Ménière's syndrome that gross dilatation of the saccule and scala media with obliteration of the perilymph space and the scala vestibuli had occurred. Five years ago I did a decompression of the vestibule with rather satisfactory but not complete relief from dizziness without any attempt at destroying the utricle.

In four cases following, the utricle was completely destroyed with complete relief of the symptoms of Ménière's disease.

Recently I performed the operation with no attempt at completely destroying the utricle but with destruction of the membrane in the ampulla of the horizontal semicircular canal which probably included the membrane proximal to the ampulla for a distance of a half to one millimeter, with equally good results.

The operation is performed under local anaesthesia, and by means of a trephine and burr through a postauricular incision the horizontal semicircular canal is exposed and the ampulla opened.

Through this opening the immediate membrane is destroyed by means of a small dental explorer. However, the membrane may be destroyed by electro-coagulation as has been advocated by Dr. Warren Day.

Thyroiditis

True inflammatory processes are far less common than other diseases of the thyroid gland. This may occur from the teen age to the fourth and fifth decades and is most commonly seen in females, doubtless because here the incidence of thyroid disturbance is higher. It occurs in varying degrees of severity, from the rare acute suppurative type to the more common subacute or chronic thyroiditis, better known as Reidel's disease.

The disease is an infectious process, but to our present knowledge no specific organism has been identified with it. Usually it follows infections of the upper respiratory tract—the tonsils, sinuses, teeth, etc.—but at times it seems to occur entirely as a separate entity and no primary foci of infection can be determined elsewhere. It may follow any acute infectious disease.—Albert J. Bowles, M. D., Seattle, Wash. Northwest Medicine, Vol. 43, No. 8, August, 1944.

A Method of Preservation of a Sterile Needle for Several Hours

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The needle is placed in glass tubing which in turn is encased in a glass vial. A day's supply of needles in such containers is then sterilized in one autoclaving. This procedure has been in use for more than two years. The results have been more than gratifying from the standpoint of sterility, dryness, convenience, less replacement, maintenance of sharper points for longer periods of time, and transparency, thus permitting one to see which gauge needle is to be used.

This method can be adapted to both hospital and office uses.

The glass tubing has a diameter of 2 mm. The tubes are cut in lengths slightly longer than the



stem of the needle. The free ends of the tube are heated and smoothed, thus preventing chipping.

Separate glass vials are used for the various sizes of needles and tubes. The capacities of the vials employed are the containers, and are of the wide-mouth type.

It is important to use plain, non-rusting and non-leaking closures. The unpainted and non-enameled aluminum cap offered the best results. Care must be exercised to prevent the loss of either the backing or facing of the cap liners. These two components of the liner, when retained in the cap, will prevent leakage of water into the vial.

The hub end of the needle, after placing in the tube, may be in either direction. It is easier to check on the gauge of the needle if placed with the hub away from the mouth of the vial.

Stilettes are not necessary with this sterilization as the needle is cleaned after use. Then air is blown through and the needle is kept dry at all times.

Primary Pneumococcic Peritonitis

H. WAYNE SMITH, M.D.

PNEUMOCOCCIC peritonitis as an entity is frequently not recognized as the primary cause in an acute abdominal emergency. The disease is essentially one of childhood, most common under the age of ten years, with about 75 per cent of all cases in the female.[1,2] About one-third of all of the cases are secondary in type. Most of the primary cases are seen in girls while most of the secondary cases are seen in boys. In very young infants and in adults the peritonitis is of the secondary type. The disease is only about 4.5 per cent as common as acute appendicitis but is of sufficient importance to demand a thorough knowledge of it by both the surgeon and the pediatrician.[3] Hygiene has little to do with the etiology of the disease.

There are clinically two types that must be recognized, the primary which we shall consider in this paper, and the secondary type. The primary type, which is also known as idiopathic pneumococcal peritonitis, is the most important because the clinical syndrome is essentially peritoneal in character and terminates fatally in a high percentage of cases, depending, however, on the chronicity and fulmination of the case to a large extent.[4] Types one and four are the predominate organisms responsible for the primary pneumococcal peritonitis.

The mode of entry of the organism is a debatable point, as yet no definite portal of entry being consistent in any group reported. There are several possible explanations offered as follows:

(a) The fallopian tubes are regarded by many as the only possible source of infection. They also point out the fact that the disease is almost entirely limited to girls at the age when the tubes are becoming patent and that pneumococci are at times found in the vaginal smears. On the other hand not all of the patients are girls and some of the cases are prior to the time when the tubes become patent.

(b) The bowel can be considered as another source of infection. While no gross lesions are present it is possible that the organism can pass through the wall by permeation.

(c) The hematogenous route is very suggestive, for many cases of septicemia are found. In about 50 per cent of the cases this precedes the onset from three to five days.[5] Some of these of course follow the onset of the peritonitis. If it be hematogenous we must suppose that there is another primary focus of the infection and these therefore should not be considered primary in the strictest sense of the word.[4] It would then appear that there is more than one method of entry and of the three mentioned above it is more likely that the first and third are the most important. If it is blood borne, it is probable that an upper respiratory infection is responsible.[3]

A report to the Ashland County Medical Society.

The Author

● Dr. Smith, Ashland, Ohio, is a graduate of Western Reserve University School of Medicine, Cleveland, 1936; 1st Lt., Med. Corps, A.U.S. on active duty.

THE PATHOLOGY

The first pathologic response is a hyperemia and edema of the intestine along with the deposition of a sticky fibrinous exudate over the serosa of the intestine and omentum as well as other proximal organs. Enlargement of the mesenteric lymph nodes is observed. Many authors have noted a hyperemia of the fallopian tubes, but since this is a pelvic condition it is questionable whether this is more than part of the general pelvic inflammation. After a day or two a thin, cloudy, yellowish green exudate with numerous flakes of fibrin develops. Fluid may accumulate in huge quantities, as much as two or three liters being taken off. Within three or four more days the fluid becomes thick and at times homogenous and a true pus.

It is at this time that the walling off process takes place. Circumscribed abscesses may form at any point in the abdominal cavity and perforation of the wall at the umbilicus may occur. Pneumonia and empyema are the two most common complications and when present are very important, contributing factors toward death.[3]

The clinical syndrome presented by this disease is largely due to the general toxemia and the infection of the peritoneum. According to the severity of the disease three fairly distinct forms can be distinguished and are as follows:

1. The fulminating form which is characterized by a sudden onset with severe generalized abdominal pain and persistent vomiting. Diarrhea with persistent vomiting may appear as an initial symptom or not until some time later. Within a few hours the patient shows marked prostration. The temperature rises early to 103 or 105 degrees accompanied by a full rapid pulse.

The abdomen is tender especially below the umbilicus and may be rigid or at times doughy. The patient's condition grows worse at an alarming rate and the vomiting may be intractable. The patient shows delirium with periods of coma. Diarrhea if present continues though some of the patients are constipated from the beginning. Cyanosis and a weak thready pulse are evident. The respirations are rapid and shallow and the temperature remains high. The decline of the patient is so rapid that death from collapse and cardiac failure may occur in from 36 to 48 hours. The leukocyte count is usually high (20,000 to 40,000), although in some of the severe cases a leukopenia may be present.

2. The acute form has a more gradual onset with colicky pain, most marked in the lower abdomen with some vomiting and malaise. The condition is well established in 24 hours. The pain becomes more intense and generalized throughout the abdomen and the fever mounts to 103 degrees or higher. Signs of pelvic inflammation and irritation now appear with tenesmus and painful micturition. The condition now tends to become stationary for a day or two with a continuation of the fever and the vomiting. Then rather abruptly the signs of generalized septicemia are ushered in with delirium and increased stupor, cyanosis, a rising temperature and a thready pulse. Soon after, if steps are not taken for supportive treatment, death ensues.

3. The subacute or chronic form represents the mildest type of the disease. The patient may have a history of a vaginal discharge for some time prior to the onset and then become mildly ill with colicky pain which soon may be followed by diarrhea and vomiting. The symptoms may continue for several days without the attack being of sufficient intensity to confine the patient to bed. In about a week the diarrhea and vomiting become less marked but the pain persists. After a few days the symptoms of infection are evident. The pulse rate increases somewhat and the temperature rises to 102 degrees. The leukocyte count is up to 20,000. The patient who up to this time has shown only moderate illness now shows signs of marked dehydration, wasting and general weakness. The abdomen at this time shows signs of moderate rigidity and the tenderness is more marked. A mass may be felt in the cul-de-sac or appendiceal region on rectal examination and at times a localized mass may be felt by abdominal palpation just above the pubic sympysis. Septicemia is the usual fatal factor in most of these cases, however some can avoid this outcome. Should a septicemia evolve, the chances of pneumonia or empyema are much increased.

THE DIAGNOSIS

In the diagnosis of these cases several points should be kept in mind. The prevalence of the condition in girls and children from two to ten years of age. The beginning of the condition as a pelvic peritonitis with painful micturition and at times diarrhea (30 per cent of the cases) but not always present. The later appearance of septicemia, especially cerebral symptoms such as delirium, coma or stupor. The fulminating form is the least likely to be diagnosed because of the tendency of the septicemic syndrome to obscure the real nature of the infection. Most of these cases are considered acute enterocolitis or acute food poisoning. The acute and subacute forms are generally easily recognized as peritonitis but may be confused with streptococcic peritonitis unless the pelvic signs are pronounced.

The appendix lying low in the pelvis may produce signs of bladder and rectal irritation and may be most confusing in both the acute and chronic forms. The milder and more chronic forms may be confused with tubercular peritonitis, but a pelvic abscess pointing at the umbilicus will probably be due to a pneumococcic peritonitis.[4] A point of distinct help in making a diagnosis is the aspiration of the peritoneum with a large needle and examining the pus. While conceivably there is some danger of visceral puncture with this method, I feel that it is more than compensated for by the diagnostic aid afforded. If an area is chosen in the hypogastrium with the patient in Fowler's position the possibility of entering an adherent loop of bowel is reduced to the minimum. Definite and proved examples of actual injury due to this procedure are lacking.[3]

THE TREATMENT

The treatment of this condition is debatable with many conflicting opinions, especially in regard to surgical intervention in the early stages of the disease. However the great majority feel that it is wiser to operate in the acute early form of the disease, in that there is greater danger in temporizing and patients may be lost due to the lack of localization or through a possible mistake in diagnosis and a pelvic appendicitis overlooked. The best results have occurred with early surgical intervention. [3,4,5] The operation should be as simple and rapid as possible in accord with the surgical technique used in the surgical treatment of any peritonitis.

The administration of glucose and blood transfusions are highly advisable. In addition, the seriousness of the condition warrants the use of a suitable anti-pneumococcic serum.[3,4,5] In the chronic cases, unless rupture and drainage are adequate, surgical intervention is necessary in order to prevent septicemia, pneumonia, and empyema. Absolute rest of the bowel is obtained by opiates, duodenal drainage and nothing by mouth. The administration of fluids in at least 3,000 cubic centimeters every 24-hour period is necessary to maintain the fluid balance.

In conclusion, it must be remembered that the cases on record are hardly of a sufficient extent to be able to draw any very conclusive data. A total of some 90 cases have been reported since the late 1800's. We must, I think, treat each case very much as an individual syndrome and vary the treatment as the case seems to indicate, following the general dictates for any peritonitis, colored by the necessities demanded of the individual treatment of primary pneumococcic peritonitis.

CASE REPORT

Chief Complaint—Sharp, knifelike pain in the abdomen with fever and vomiting of 24-hour duration.

Past History—The patient was a breech delivery with a birth weight of seven and one-half pounds. Breast fed until 11 months. Cod liver oil given in sufficient quantities and orange juice in sufficient amounts after the second month only. The weight curve was normal throughout entire growth period. All diseases have been severe. Chickenpox at three months of age and mumps, whooping cough and measles all within the fifth year of life and in that order. Has always had leg ache. No severe injuries or operations. Balance of history negative.

Family History—Mother and father living and well. One sister, age sixteen, in good health. No history of familial disease.

Present Illness—About six months ago the patient complained of pain in the right lower quadrant of the abdomen of sufficient intensity to make her cry out. Moderate fever and nausea but no vomiting. The attack lasted from 24 to 36 hours and was relieved by enemas. There have been five recurrences at irregular intervals within the past six months.

At this consultation the patient began to have pain in the epigastrium and nausea with an associated feeling of lassitude. On the following day she began to run a fever of low degree and complained of headache, pain in the lower extremities, and tender and painful abdomen especially in the right lower quadrant. There were three bouts of vomiting, the emesis being a clear green fluid. At this time castor oil was given without consultation, and without relief of the pain, nausea or vomiting. On the third day of the illness the patient developed a marked dysuria and the pain and tenderness in the right lower quadrant of the abdomen became more severe. At no time was diarrhea or rigidity noted. The patient sat up with difficulty but there was no evidence of muscular weakness or neurological abnormalities. The patient would at times, however, show signs of cerebral irritation in the form of mild delirium of short duration. The patient was moderately constipated.

Physical Examination—Temperature 103.8 degrees. Pulse 160 full and bounding. Respiration 36 and regular. A well-developed and well-nourished appearing white girl age eight years lying flat in bed who appears moderately ill. The patient is irritable but cooperative. The examination reveals nothing abnormal save the abdomen and rectal digitalization. The abdomen is flat with moderate rigidity on the right and moderate tenderness in both lower quadrants and moderate rebound tenderness in the right lower quadrant. No meteorism elicited. No masses palpable. The rectal examination revealed marked tenderness in the appendiceal region and a moderately well-circumscribed mass in the same area. There was moderate tenderness in the cul-de-sac but no masses felt. The left adnexa was negative. The urinalysis was normal. The white blood count was 21,000 with a predominance of polymorphonuclear leukocytes. An enema was advised and an ice bag to the right lower quadrant. Nothing by mouth.

On the fourth day of the illness the abdominal rigidity was present on both sides of the abdomen and had definitely increased. The tenderness in the right lower quadrant was more marked. The patient held the right thigh in acute flexion and complained of pain with extension. The patient was definitely stuporous and at times delirious. Codeine was given for the discomfort.

Seven hours later the abdomen was boardlike and extremely tender. At this time the patient was hospitalized and a diagnosis made of acute appendicitis with possible rupture and early peritonitis. A laporotomy was performed three hours later. On opening the abdomen there was found an odorless, green, chylous fluid with generalized inflammation of the intestines and a sticky plastic exudate at intervals along the ascending and transverse colon. The appendix was markedly inflamed and edematous with plastic exudate adherent to the serosa. The pelvic organs were apparently normal. No Meckel's diverticulum was found. A culture of the peritoneal contents was taken and the appendix removed with the stump buried and a routine closure with silk worm gut for the skin. One cigarette drain was placed in the pelvis.

On returning from the operating room, duodenal drainage was instituted with a continuous rectal tube, Fowler's position, and an ice bag to the abdomen. Prostigmine and opiates were the only drugs used at this time.

On the fifth day of the illness or the first postoperative day nine cubic centimeters of prontosil was given and followed with the same dosage at four-hour intervals for 12 doses. This was reduced to three cubic centimeters and given for six additional doses at four-hour intervals. The duodenal drainage was discontinued on the fifth postoperative day since the abdomen was soft and the stools essentially normal with the free expulsion of flatus. The peritoneal culture showed Type 1 pneumococcic with the Neufeld reaction.

Later during the first postoperative day there was some moderate distension of the abdomen and the general condition of the patient appeared fair but moderately toxic. A positive blood culture showed Type 1 pneumococcic. A transfusion of one hundred cubic centimeters of whole citrated blood was given with 5 per cent glucose in normal saline, which incidentally was pushed to tolerance during the entire course of the disease either as intravenous or hypodermoclysis. Ten thousand units of Type 1 anti-pneumococcic serum was given intravenously and followed three hours later with 30,000 units which again was followed by 10,000 units after a three-hour interval. During this period the temperature was between 104 and 105 degrees and the patient extremely toxic.

On the second postoperative day and 10 hours following the last injection, 60,000 units more of Type 1 anti-pneumococcic serum was given, largely because of the positive blood culture. Forty-five minutes later a slight urticaria was noted which was completely controlled by a hypodermic of one-half cubic centimeter of adrenalin.

A blood culture was taken later in the same day but proved to be positive. The leukocyte count, however, dropped from 30,750 with 39 stabs to 14,300 with 46 stabs.

On the morning of the third postoperative day there were definite signs of improvement with the temperature dropping to 102.2 degrees, pulse 124 and respiration 30. The patient was expelling flatus, the color improved, the abdomen was soft and only a small amount of drainage was evident. A transfusion of whole citrated blood was given at this time.

On the fourth day of the postoperative period the temperature was 100 degrees, pulse 100 and respiration 24 with the patient resting easily. The patient had no complaints but was rather irritable. The temperature rose in the afternoon to 101.2 degrees. Another blood culture was taken and this time proved to be negative after an eight-day growth period. The leukocyte count was 14,000 with 15 stabs.

On the sixth and seventh post-operative days the stools ceased to be liquid save very occasionally and became soft, brown and well formed with expulsion of flatus. The patient, however, complained of a pleuritic pain in the right chest posteriorly, and there was a large amount of drainage from the abdominal wound. A thoracentesis was done with 10 cubic centimeters of thin, cloudy, straw colored fluid removed and cultured. The culture showed no growth in an eight-day period. The chest motion was reduced by adhesive tape straps. One hundred and fifty cubic centimeters of whole citrated blood was given at this time. A tuberculin patch test was run and a negative reaction was obtained.

The temperature then ran between 99 and 100.6 degrees with the condition of the patient remaining satisfactory until the 13th postoperative day when she complained of pain in the inner surface of both thighs. The temperature went to 102 degrees. The legs were elevated and ice applied. The leukocyte count rose to 30,400 with 11 stabs. A soft diet was started at this time, however, and was thoroughly enjoyed.

On the 17th postoperative day the temperature dropped to 100 degrees and one-half cubic centimeter of foreign protein with manganese butyrate was given intramuscularly and on subsequent alternate days one cubic centimeter was given for a total of five doses. The patient was discharged from the hospital on the 17th postoperative day.

During the course of the disease the urine showed moderate traces of albumin and a few granular and epithelial casts which was interpreted as being associated with the general toxemia and not directly related to the primary condition.

It perhaps should be mentioned that on the 13th day of the hospital stay sulphanilamide with sodium bicarbonate was given in 10 grain doses every four hours but the patient became quite cyanotic and the respiration labored so the dosage was reduced to 5 grains and continued for four days without any appreciable benefit noted.

One can not draw satisfactory conclusions from the study of one case but several interesting points can be brought out. First of importance is the close similarity of this condition to that of acute appendicitis with early perforation. Even upon laparotomy there was a question of diagnosis and not until we got a culture report could a definite diagnosis be made. Granted, however, that it was an acute appendicitis the temperature was high and the patient did not appear as acutely ill as those afflicted with appendicitis usually do, still we could not definitely rule out the condition because of the wide variances seen in children. I felt justified in making the diagnosis of acute appendicitis with peritoneal involvement and treating it as an acute surgical abdomen.

The second interesting point is the use of anti-pneumococcic serum in large doses to combat the acute and severe toxemia associated with the condition and which is so much responsible for the high mortality rate. The use of prontosil in this instance was of a supportive therapeutic nature in that the drugs that were available were greatly limited. There is material in the literature suggesting its use but in this case it is to me somewhat doubtful whether it was of any real value except perhaps as a prophylactic against complications. The balance of the treatment was undoubtedly important but largely supportive in type.

The question will arise as to the advisability of performing an appendectomy in the face of peritoneal infection. But here again in the face of a definitely limited spread of the infection and the extensive involvement of the appendix itself we felt justified in proceeding. Sulphanilamide has apparently a low specificity for Type 1 pneumococci and results with its use postoperatively have not been favorable and, so far as this case is concerned, largely a matter of experimental interest. It must be noted that it was not used until the 13th postoperative day.

SUMMARY

In summary the following are important:

1. The intervention of surgery in a case of this type is indicated.
2. That large doses of type anti-pneumococcic serum are important and definitely alter the prognosis of the case.
3. That prontosil and sulphanilamide (especially the former) are perhaps prophylactic agents against complications but of doubtful therapeutic value.
4. That the usual supportive treatment and routine management for peritonitis including repeated blood transfusions are important and necessary.

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Spontaneous Rupture of the Spleen in Chronic Myeloid Leukemia*

MAURICE M. GREENFIELD, M. D., and HERBERT LUND, M. D.

Case History. R. C., a 44 year old colored female, was first admitted to Cleveland City Hospital on Oct. 9, 1942, with the complaints of poor appetite, weakness and loss of weight. These complaints had become progressively more severe over a period of one year. A chest roentgenogram showed a solitary spherical lesion about 5 cm. in diameter in the left lung. This was interpreted as tuberculosis in spite of the fact that acid fast bacilli were never demonstrated in the sputum or gastric washings. There were splenomegaly, hepatomegaly and several enlarged lymph nodes in both axillae. In the peripheral blood, leucocytes numbered 227,000 per cu. mm. and smears showed numerous myeloblasts, promyelocytes and myelocytes.

A diagnosis of chronic myeloid luekemia was made and the patient was treated with high voltage roentgen therapy to the spleen receiving a total of 1400 r. The leucocyte count diminished to 9300 cells per cu. mm. in a period of 3 months and, because the pulmonary lesion appeared inactive and the patient asymptomatic, she was discharged on Feb. 2, 1943.

She was readmitted on Jan. 10, 1944, complaining of severe steadily increasing abdominal pain, nausea and vomiting. These symptoms were of three days' duration.

Upon admission the patient did not appear acutely or seriously ill. Her temperature was 38.2° C., pulse 128, respirations 28, and blood pressure 128/68. The spleen was enlarged, extending to the level of the iliac crest, and exquisitely tender. There were no other significant findings on physical examination.

The peripheral blood contained 11 Gm. of hemoglobin per 100 cc. and erythrocytes numbered 2,870,000 per cu. mm. There were 82,100 leucocytes per cu. mm., of which about 46 per cent were "blast" cells. The blood urea nitrogen was 39.9 mg. per 100 cc., creatinine 1.6 mg. per 100 cc., and the icteric index 11. Kline diagnostic and exclusion tests were negative.

The patient was treated symptomatically for 70 hours with little change in the symptoms. Then she suddenly became worse showing signs of peripheral vascular collapse with a rapid thready pulse and cold clammy skin. She was started on intravenous fluids and whole blood transfusions but failed to improve and died on the fifth hospital day.

The clinical diagnoses were (1) chronic myeloid leukemia and (2) infarction of the spleen.

PATHOLOGICAL FINDINGS

The autopsy was performed five hours after death. On opening the peritoneal cavity about 1000 cc. (estimated) of dark red, clotted blood was found. The greater portion of this blood was present beneath the left leaf of the diaphragm.

The spleen weighed 500 Gm. The diaphragmatic surface was covered with dark red blood clots. The capsule was slightly thickened, the spleen moderately firm and reddish-purple. There was a tear in the capsule along the posterior margin near the lower pole measuring 3 x 0.5 cm. The ruptured capsule was reflected towards the hilus and to it was attached a small amount of splenic pulp. The tail of the pancreas was adherent to the reflected portion of the capsule by dense fibrous adhesions. On section there were several pale gray, firm, triangular-shaped infarcts averaging about 3 x 2 x 1.5 cm. The largest of these was beneath the diaphragmatic surface of the spleen. The pulp was moderately firm, light red and mottled with poorly defined, irregularly shaped, gray areas averaging about 8 x 5 mm. The malpighian follicles could not be seen. There was no recent infarct at the site of rupture. The splenic artery and vein showed no thrombus or embolus.

The sternum, ribs and vertebrae contained soft, pale red marrow. The marrow of the femoral shaft was red although a little fat could be detected.

Histologically there were foci of hemopoiesis in the spleen and lymph nodes. The sternal marrow was completely hemopoietic and that of the femoral shaft, normally non-hemopoietic, was about 90 per cent cellular. There was hyperplasia of all cellular elements including megakaryocytes but the myeloid elements appeared relatively increased in comparison with the erythroid. Eosinophils were numerous. There were many large, nongranular, moderately basophilic cells interpreted as "blast" forms. There was no leukemic infiltration of the heart, kidneys, liver or brain.

The major pathological diagnoses were (1) chronic myeloid leukemia, (2) rupture of the spleen with intraperitoneal hemorrhage (1000 cc.), (3) multiple recent and remote infarctions of spleen, (4) fibrous peritoneal adhesions of spleen, (5) chronic fibroid and ulcerative tuberculosis, left upper lobe, probably inactive, and (6) bronchopneumonia, bilateral.

DISCUSSION

Spontaneous rupture of the spleen in leukemia is uncommon. Rubnitz[3] in reviewing the literature found only 7 cases. Lange[1] investigated 189 cases of spontaneous splenic rupture and found only 5 associated with leukemia. He adds a case of his own. One more case was recorded in 1940 by Neal[2].

The mechanism of spontaneous rupture of the spleen in leukemia is not clear. It may be that minor trauma coincident to increased intra-abdominal pressure associated with simple physiological acts of sneezing, coughing, lifting, etc., is a significant factor. This is difficult to

*Selected by H. T. Karsner, M. D., from the Clinical-Pathological Conferences at Cleveland City Hospital, Cleveland, Ohio, as the twenty-third of a series of cases to be published under the heading "Case Records Presenting Clinical Problems".

evaluate particularly since in many cases of ruptured spleen there is no history of injury. In one case of leukemia reviewed[2] the author questioned whether the simple administration of an enema to the patient might not have been related to the splenic rupture.

Another factor in spontaneous rupture of the leukemic spleen is infarction. It is well known that this occurs commonly, some authors stating that infarcts are seen in as many as 50 per cent of all cases of myeloid leukemia. The rupture coincidental to infarction may be of the so-called "delayed type". In this, there is gradual subcapsular bleeding at the site of infarction, followed by increased tension on the capsule until it tears.

Spontaneous rupture of the spleen in leukemia, judging from the cases reviewed, is invariably undiagnosed clinically. It is most frequently confused with splenic infarction, with which it may be associated. The symptoms and blood findings characteristic of leukemia often disguise the evidence of acute hemorrhage. The presence of pallor, weakness, anemia and leucocytosis are of little diagnostic value since they are usual in leukemia. In the case cited, it was only when vasomotor collapse occurred that the serious condition of the patient was appreciated.

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Treatment of Acute Conjunctivitis With Tyrothricin

CARL J. STREICHER, M.D., CANTON, OHIO

It is desirable in the treatment of any type of acute conjunctivitis to bring the infection under control as quickly as possible, not only for the comfort of the patient and the avoidance of further ocular complications, but also to prevent the spread of a highly contagious infection to the fellow eye or to other individuals. With the usual antiseptic agents for treatment of acute conjunctivitis this is accomplished in an average of five to seven days.

In the past few months all patients with an acute conjunctivitis have received the following treatment and without exception, the disease has subsided within a 24- to 48-hour period. Microscopic examination of smears from the conjunctiva has exhibited infections due to pneumococci, staphylococci, streptococci, and mixed types. There have been no cases of conjunctivitis due to the organism of gonorrhea in this period of time.

The vision of the patient is first obtained before any treatment is begun. This is necessary information which should be obtained from any patient with an eye complaint. After obtaining a smear from the conjunctival cul-de-sac for microscopic examination, a drop of pontocaine solution one-half percent is instilled. If there is marked conjunctival chemosis with purulent secretion, the conjunctival surface is everted and painted lightly with a one percent solution of silver nitrate. The caustic action of this treatment creates a superficial eschar which removes entangled organisms. An ointment of sulfathiazole ophthalmic five percent is prescribed with directions to be used four times a day. The ointment aids in preventing the adherence of the lids and lashes as a result of the purulent secretion, together with the questionable bacteriostatic effect of the sulfa drug. The patient is given a freshly prepared soluton of tyrothricin, one or two drops to be instilled in the affected eye or eyes every two hours daily until retiring.

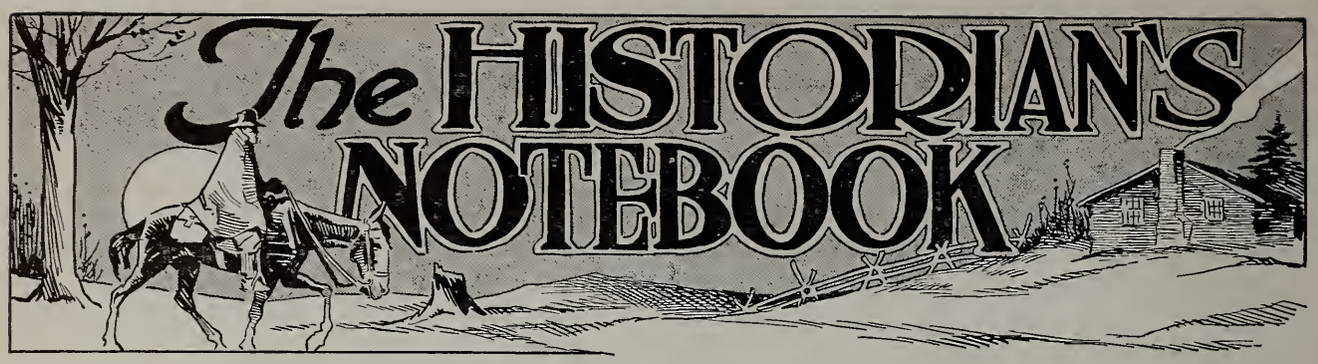
The solution of tyrothricin must be freshly prepared and renewed in 24 to 36 hours if continued use is desired. Laboratory tests report that the solutions prepared from the stock source become unstable after 24-48 hours. One-tenth of a cubic centimeter of the stock solution of two per cent tyrothricin (Parke Davis & Co.) is withdrawn using a tuberculin syringe. This amount is then added to eight cubic centimeters of sterile distilled water in a dropper bottle.

SUMMARY

The rapid and effective clinical response to the above outlined treatment has been so gratifying that the author feels that it is worthy of wider application. There has not been an instance in which there has been any evidence objectively or subjectively of irritation in the eye from the use of tyrothricin.

Tuberculosis Compensable?

It has been argued that if tuberculosis were made uniformly compensable, it would soon be wiped out; but it is obviously unfair to ask industry and the insurance carrier to take upon their shoulders the accrued liabilities of tuberculosis in industry. When industry and the worker realize the terrible cost in manpower and human suffering that tuberculosis entails and that a method of control is feasible, then case finding in industry will be more eagerly accepted and may in fact, be one of the outstanding contributions toward public health that will survive this war.—Irving R. Tabershaw, M.D., Industrial Medicine, March, 1943.



Kept by David A. Tucker, Jr., Cincinnati, Ohio

Historical Notes on the Northwestern Ohio Medical Association

JONATHAN FORMAN, B.A., M.D.

AT a meeting of the Allen and Van Wert Medical Societies held at Lima on April 4, 1869, a joint resolution was adopted that the two societies meet in Lima again on the first Tuesday in June and that regular physicians of Hardin, Auglaize, Putnam, Mercer and Hancock Counties be invited to meet with them for the purpose of organizing a district medical society.

In compliance with the above resolution a large number of physicians assembled in Lima at the appointed time. On motion of Dr. Philips of Kenton, Dr. Harper of Lima was elected temporary chairman. On motion of Dr. Williams of Ada, Dr. Baxter of Lima was elected temporary secretary. As the result of a motion by Dr. Weiner of Lima a committee was appointed to draw up a constitution and by-laws for the society. On this committee each of the several counties were represented, viz., Dr. Weiner of Allen County, Dr. Schackelton of Auglaize County, Dr. Philips of Hardin, Dr. Morris of Putnam, and Dr. ..... of Van Wert.

On motion of Dr. Thrift of Allen County the chair appointed a committee to nominate a list of officers. On this committee were Dr. Thrift of Allen, Dr. Cessua of Van Wert, Dr. Schackelton of Auglaize, Dr. Watt of Hardin, and Dr. Paul of Putnam.

After dinner the committee on Constitution and By-laws reported and their report accepted. The proposed constitution was taken up section by section and adopted.

Following the adoption of the Constitution and By-laws, the first officers were duly elected. President, Dr. W. H. Harper, Lima; vice presidents, Drs. W. H. Philips of Hardin and C. Berlin of Auglaize; secretary, Dr. J. Moon of Van Wert; assistant secretary and treasurer, Dr. Baxter of Allen.

For the standing committees, the following: **Ethics,** Drs. Godfrey, McHenry and Watt; **Admissions,** Drs Longsworth, Schackelton, and Williams; **Publications,** Drs. Weiner and Baxter; **Delegates to the Ohio Medical Society,** Drs. Philips and Berlin.

Dr. McHenry read the first paper, "Hemorrhoids and Prolapsus Ani". Thus the society got off to a good start as a district society and as an auxillary to the Ohio State Medical Association. Its constitution provided that it should meet in December and June of each year.

The December meeting that year was held in Van Wert on the 14th. Seven names were presented for membership and each considered separately. Objection being offered to one, his name was withdrawn and the remaining six were elected to the society. An item in comparative costs is interesting in that the committee reported that 150 copies of the constitution and by-laws had been printed at a cost of $20.00. Dr. S. B. Hiner read the main paper on "Pyemia"

The Author

● **Dr. Forman, Columbus, Ohio, is Chairman of the Committee in Medical History and Archives, Ohio State Archeological and Historical Society.**

*Abstracted from the original minutes of the Northwestern Ohio Medical Association.

The 100th meeting of the Society is scheduled for Oct. 3, 1944, at Findlay.

followed by a general discussion and several case reports.

On June 2, 1870, the society held its Spring meeting in Kenton. Dr. W. H. Philips was elected president, and C. M. Godfrey and E. L. Schackelton vice-presidents. Dr. S. A. Baxter read a paper on "The Relation of Emotions and Disease". Dr. Weiner read a volunteer paper on "Meddlesome Midwifery". Drs. Menison, Stansell, Young, and Ballard were appointed to be delegates to the Ohio State Medical Society. Drs. William Watt and E. L. Schackelton were appointed essayists for the next meeting to be held in Wapakoneta. The secretary was instructed to furnish a synopsis of the proceedings for publication in the several county papers.

On December 4, 1870, the society reassembled in Wapakoneta as agreed upon. Consideration was given to the idea of publishing the proceedings in pamphlet form and it was decided to be impractical at the moment.

Dr. E. L. Schackelton read a paper on "Cholera Infantum" which was well received. Drs. R. W. Thrift and C. Berlin were selected as essayists for the next meeting to be held in Celina, and Drs. Paul and Williams as alternates.

On June 1, 1871, the meeting was held in Celina with 14 members present. The following new officers were elected: For president, Dr. C. M. Godfrey; for vice-president, Drs. J. N. Hetzler and J. L. Reid; for secretary, Dr. S. A. Baxter; for assistant secretary, Dr. A. N. Kraut. The office of treasurer was separated and given to Dr. C. Berlin.

After a splendid dinner Dr. W. H. Philips, the retiring president, delivered his valedictory address on "The History and Progress of Medicine". Dr. Munson also read a paper on "Laws Regulating the Practice of Medicine in Ohio". Dr. R. W. Thrift on "Obstetrical Accidents and Their Remedies". Dr. C. Berlin on "Etiology of Epidemics" and Dr. Bradley of St. Marys exhibited an apparatus of dry cupping and explained its use.

At this meeting a constitutional amendment was proposed broadening the requirement of residence to all regular physicians in North western Ohio.

On December 7, 1871, the Winter meeting was held at Ottawa with an attendance of 18. At the afternoon session Dr. H. D. Ballard read a paper on "The Use of Plaster of Paris Bandages in the Treatment of Fractures". This brought an interesting and lengthy discussion. At the evening session Dr. McHenry read a paper on "Primary Zoology".

On June 6, 1872, the society met in Findlay where it elected officers; for president, H. D. Ballard; for vice-presidents, J. M. Shoemaker and S. B. Hines. On a motion by Dr. A. Hurd a committee of three were appointed to investigate Dr. C. S. Lafferty as to his qualifications to practice. The committee reported favorably provided the gentleman would agree to complete the requisite course of lectures during the coming Winter.

In his absence, Dr. J. L. Woods' paper on "Gunshot Injuries of the Knee Joint was read for him and received general discussion. Dr. W. H. Philips read a paper on "Spinal Irritation". Dr. B. B. Leonard exhibited a number of Calculi which had been extracted from his own bladder.

The Winter meeting in 1872 was held on the 4th of December at Lima. The Hon. James Mackenzie delivered an address on "Medical Evidence". The first deaths among the members were recorded and eulogies were given on the lives of Drs. Ballard and Underwood. The Bar Association of Lima gave the physicians a splendid banquet at one of the hotels.

The next morning after a short business session, Dr. J. N. Williams read a paper on "The Five Senses". The main paper, however, was one by Dr. Hurd on "The Use and Abuse of Alcoholic Stimulants in the Treatment of Disease". Again a committee was appointed to report on the possibility and the feasibility of publishing the proceedings.

One-Third of Discharged Veterans Are Filing for Disability Pension

Out of every 100 veterans discharged from World War II, 32 have filed claims for disability pension and two-thirds of the claims adjudicated have been allowed, Brig. Gen. Frank T. Hines, chief of the Veterans' Administration told delegates to the recent convention of the Disabled American Veterans.

With disabilities the major cause for discharges thus far, the General said that neuropsychiatric disabilities comprised 40 per cent of the claims approved.

In his prepared address he said there were 229,336 World War II veterans on the pension rolls at the end of July, and the dependents of 30,737 deceased veterans were receiving pension payments.

Presenting a picture which will be enlarged as the war's toll grows, General Hines said hospital admissions have more than doubled in the last year, with the veterans of this conflict making up 20 per cent of the 15,288 service men hospitalized by the Veterans' Administration.

Present hospital facilities, plus those under consideration, total 108,500 beds. After hostilities cease, he said, the bed capacity will be augmented by transfers of hospitals to the administration from the Army and Navy.

"Although many men have thus far been discharged for disability", he said, "comparatively few have availed themselves of the right to vocational training."

This Form Suggests How To Make a Good Periodic Health Examination; You Can Get Supply From the A.M.A.

EVERY physician should be prepared to make a good periodic health examination of his patients. What information should be obtained for the history and how the examination should be conducted are indicated in the following Periodic Health Examination blank prepared by the American Medical Association. Blanks may be obtained from the American Medical Association at reasonable cost—for example, 75 cents per hundred in quantities of 100 or more, or $4.50 for 1,000 blanks.

Form A — **HISTORY FORM**

Use check mark (√) in making affirmative answer to questions wherever possible.

1. **Name** — **Country of Birth**
2. **Address** — **White** — **Colored**
3. **Age** — Religion — **Single** — **Married** — **Widowed** — **Divorced**
4. **Present occupation** — **Began**
5. How often have you changed your work and why
6. **What are the conditions of your work** — **Do you like it**

Regular	Dangerous	Dark	Smelly	Hot	Seated	Hours per day
Satisfactory	Fatiguing	Light	Noisy	Cold	Standing	Days per week
Monotonous	Indoors Out	Dusty	Crowded	Damp	Walking	Vacation

What substances or processes in your work produce:
Dust (what kind) — Workroom:
Fumes (what kind) — Temperature
Skin irritation — Humidity

7. Are your earnings sufficient to support yourself and dependents comfortably, well, passably, poorly.
8. **What are your home conditions**

In a family	Congenial	Quiet	Room and bed to yourself
Alone	Depressing	Irritating	Time to yourself

9. **What are your sleeping conditions**

Hours in bed	Windows open	Restful	Disturbed

10. **How often do you eat**

Regularly	Where	Between meals	Time of meals

11. **Are you a moderate or hearty eater, taking one or more helpings at a meal of**

Meat (including fish and eggs)	Pie, Cake or Pastry	Salads
Baked beans	Sweets or Sugar	Bread
Green vegetables (spinach, cabbage, etc.)	Fruits	Butter
Potatoes (rice, macaroni or cereal)	Condiments	

12. **How much do you drink daily of**

Milk	Tea	Soft drinks
Water	Coffee	Alcoholic drinks

13. How frequently do you use candy — **How much tobacco**
14. **Do you have a movement of the bowels daily** — With the use of drugs
15. **What exercise do you take in addition to your work**
16. What are your social, religious, political, club or trade associations
17. What are your pleasures, recreations or hobbies — Do you take vacations — How often — What kind
18. **Are you subject to worries** — **Moods** — **Periods of alternating gloom and cheerfulness**
19. **Have you ever been ill with any of the following, or any other severe illness and at what ages**

Measles	Typhoid Fever	Tonsillitis (Sore Throat)	Pleurisy	Bleeding
Whooping Cough	Malaria	Frequent Colds	Tuberculosis	Discharges
Scarlet Fever	Syphilis or Gonorrhea	Bronchitis	Migraine or Neuralgia	
Diphtheria	Rheumatism	Pneumonia	Convulsive Seizures	

19A. **Do you ever have**

Loss of appetite	Nervous breakdown	Shortness of breath	Boils—Sties	Blood
Nausea or vomiting	Cramps	Cough	Trouble with urination	spitting
Headaches	Palpitation	Swellings	Chest pain	

20. **Have you been protected against smallpox — typhoid — diphtheria — or other diseases by vaccination — Routine Wassermann**
21. Have you had any accidents, broken bones or surgical operations
22. How often do you consult your dentist — When last
23. **Are your parents, brothers and sisters, wife or husband, children living**
    If not, what were the causes of death and at what ages
24. Have either of your parents or any brother or sister had tuberculosis — Cancer
    Insanity — Epilepsy — Gout — Diabetes — Heart disease
25. **Do you consider yourself in good health** — If not, what is your complaint

For Women

26. **Are your monthly periods regular** — Prolonged — Excessive
27. **Have they interfered with your occupation** — In what way
28. **Have pregnancies and confinements been free from accident.**
29. Tell the doctor about any unsatisfactory situations in your sex life.

Form B **PHYSICAL EXAMINATION RECORD (RECORD ONLY MEASUREMENTS OR ABNORMALITIES)**

Name Case No. Date

1. Height
3. Chest measure
Inspir.
Expir.
4. Girth (abdom.)

2. Weight, Present
Usual
Standard (for age and height)
Recent loss or gain

5. Pulse Sitting
After exercise
2 minutes later
5a. Bl. Pres. { Syst. / Diast.

6. Temp.

I. Standing

7. Posture
8. Musculature
9. Nutrition
10. Skin
11. Superficial glands
12. Female breast
13. Hands
14. Arms
15. Male genitalia
16. Hernia
17. Hips, legs, knees
18. Ankles, feet
19. Romberg sign
20. Visceral ptoses

II. Sitting

21. Hair
22. Eyes

Vision R Corrected R Reflexes Ophthalmoscopic
L L Lids

23. Nose
24. Teeth
25. Gums
26. Tongue
27. Tonsils
28. Pharynx
29. Ears

Hearing R
L

30. Neck—Thyroid
31. Chest
32. Heart, arteries
33. Lungs

III. Lying down

34. Abdomen
35. Reflexes
36. Sensation
37. Liver
38. Spleen
39. Kidneys
40. Prostate gland
41. Female genitalia, breasts
42. Rectum (hemorrhoids)

IV. Laboratory

43. Urine: appearance Sp. Gr. Alb. Sugar Sediment
44. Feces (when indicated): appearance Blood Parasites
45. Blood Hemoglobin % Stained smear
46. Other

V. Summary: Defects of function and structure and errors of habit.

VI. Advice given to the patient:

Speakers at the recent joint meeting of the American Roentgen Ray Society and the Radiological Society of North America included the following Cleveland physicians: Dr. John Robert Andrews and Capt. Robert O. Turek, "Planigraphy: An Evaluation of the Method in the Diagnosis of Cancer of the Lower Respiratory Tract"; Dr. Russell L. Haden, "Hematological and Clinical Characteristics of the Leukemias".

According to a study just completed by the statistical laboratory of the State Division of Safety and Hygiene, there were 4,925 hernia claims filed with the State Industrial Commission in 1943. Of these, 4,615 were inguinal; 75, umbilical; and 235, femoral ventral or recurrent. The average loss of time from all hernia cases was over 67 days.

Health and Human Resources in Rural Ohio

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Installment No. 2

(Continued from September, 1944, issue)

THE human resources of any nation, state, or locality are represented in the people themselves. These resources include their skills, their education, their reproductive capacities, their capacities for self direction, and their all-around capacities for personally satisfying and socially useful living.

The 1940 census counted a total of 6,908,000 people in Ohio. Of these 1,070,000 lived on farms. An additional 1,224,000 lived in rural-nonfarm homes outside centers of 2,500 or more population. The remainder of the population, totaling 4,613,000 or 66.8 per cent of the people of Ohio lived in urban places. A little more than 59 per cent lived in metropolitan districts in and around the 10 largest cities of Ohio.

Changing Age Structure. Since the incidence of death, disease, accidents, mental breakdown and other health factors are closely associated with age, any substantial change in the age structure greatly affects the whole problem of health.

The farm population of Ohio was first enumerated separately in 1920. At that time there were 1,134,000 people living on farms in this state. Between 1920 and 1940 the percentage change in the farm population was not great, and the change in total numbers was represented by a decline of only 64,000. During this 20 year period, however, there occurred a major change in the age structure of the population. Due to declining numbers of births after 1924 and to declining death rates among people under 50, the population began to age rapidly with consequent decline in numbers of children and increases in old people. In 1920 farm children under 15 years old numbered 364,000 and comprised 32.1 per cent of the farm population; in 1940 they numbered only 280,000 and comprised only 26 per cent of the farm population. In other words, farm children declined 84,000, a decrease of nearly one-fourth in 20 years.

While the numbers of children in the population were declining from 1920 to 1940, the numbers of old people were increasing rapidly. In 1920 Ohio's population included 319,000 aged people 65 years old and over, of which 74,000 lived on farms. In 1940 these old people numbered 540,000 of which 101,000 were living on farms. The proportion of aged people in the total population increased from 5.6 per cent to 7.9 per cent. Their proportion of the farm population increased from 6.5 per cent to 9.5 per cent.

EDITOR'S NOTE: This is the second installment of a study made by Dr. Mangus and which is being reproduced in The Journal with his consent. The first installment appeared in the September issue. Additional installments will appear in future issues.

It is hoped that Ohio physicians will clip these articles and keep them for study and reference. As we pointed out in September, "physicians of Ohio should have access to information of this kind so that they will be better prepared to assist in constructive planning and action."

The next census in 1950 will show a further decline of considerable magnitude in numbers of children 10-14 years old due to shortages of births during the period 1935-1939. There will also be fewer youths 15-19 years old as a result of the depressed birth rate in the early 1930's. The 1950 census will, however, show a decided increase in numbers of children 5-9 years old, reflecting the big increase in births during the first half of the present decade. The number of children under five years old in 1950 will, of course, depend upon what trend the birth rate takes after 1944.

The numbers of aged people 65 years old and over will continue to increase for many years as those in the crowded middle years move on to the older age levels.

Differential Reproduction. Any thoroughgoing plan for determining preventive health measures must take into account not only changes in the age structure but also differential reproduction among different social classes. All studies of recent years have shown that under-privileged families have more children than do those families occupying higher positions in the scale of living. There are many who believe that this condition of differential fertility has a tendency to lower the average quality of the population from generation to generation. Before attempt-

ing to evaluate this point of view, it may be well to point out some of the essential facts pertaining to the question.

It has already been pointed out that birth rates are much higher among rural people than among urban residents. It is well known, for example, that birth rates in urban places before the war were not high enough to reproduce city populations permanently. Temporarily Ohio cities were substantially increasing their numbers through excesses of births over deaths. They were, however, doing this only because of a favorable age distribution which included large proportions of women in the most fertile period of the child-bearing ages, and a comparatively smaller proportion of people at the older age levels where death rates are highest. Since this is obviously a temporary condition of the urban population, cities must eventually either increase their birth rates substantially or else depend entirely upon migration from the rural areas for maintenance of their numbers. During recent years there has been a very large increase in birth rates. However, the recent large increase in births is probably only a temporary response to war times rather than a reversal of the long time downward trend in over-all birth rates.

Of even greater importance from the point of view of human conservation is the differential reproduction rate among different social and economic classes. Such differences in population fertility are characteristic of both urban and rural areas. Differential birth rates in urban areas have been studied in connection with the population included in the National Health Survey. For that group it was found that the birth rate was in inverse proportion to socio-economic status and was 47 per cent higher among unskilled laboring groups than in the business class. Even more striking differences were found among families in the survey when they were classified according to income level. The lowest birth rate was found among those families with annual incomes ranging from $2,000-$3,000. Each lower income level was associated with an increasingly higher rate of fertility. The birth rate among families with an annual income of less than $1,000 was nearly twice as high as among families with an income of between $2,000-$3,000. Somewhat higher birth rates were found, however, among families with annual incomes of $3,000 or more. Another significant finding was that the birth rate among women with less than seven grades of schooling was 44 per cent higher than among high school and college trained women.[6]

Recent Ohio studies show that differential rates of reproduction among level-of-living classes are equally characteristic of rural areas. A study of census data for 1940 reveals wide area differences in fertility ratios within the farm population. Fertility may be measured in terms of the number of children under five per 1,000 women 20-44 years old. In 1940 this fertility ratio for farm women in Ohio was 42.3 per cent higher in those counties having the lowest level of living than in those counties where the average level of living was highest. Other studies show that reproduction rates are higher among the poor than among the more well-to-do farm families. A recent study of the rural youth, 18-27 years of age of Ross County, Ohio, was very revealing in this respect. The proportion of those young people with five or more brothers and sisters was twice as great among the least privileged as among the most privileged one-fourth. Moreover, the women in the lowest level-of-living class represented by Ross County rural youth had themselves given birth to about four times as many children as had those young women in the highest level-of-living class. The percentage of high school graduates among the most advantaged women who had the lowest birth rates was 4.5 times higher than among the most disadvantaged women who had the highest birth rates. As a matter of fact, only 18 per cent of the most under-privileged women had graduated from high school.[7]

It seems clear that considerably more than half of Ohio's future citizens are being born in that half of the homes which are least well equipped economically, socially, and educationally to rear the highest types of citizens. The significance of this fact from the point of view of conservation of human health and human resources is obvious. There is no unchallenged proof that the average genetic quality of underprivileged peoples is lower than that of the more privileged groups. Apart from biological considerations, however, there is a definite need for having much larger proportions of babies born and reared in better home environments. An effective program for accomplishing that objective would go far toward improving the average quality of the population, by removing severe handicaps to good health, by adequate education and training, and by highest personal happiness and social usefulness. In the final analysis it may be that improvements in the home environments in which children are reared may offer the greatest promise for improvement in the health and other qualities of the rural population.

Migration. Another factor which affects the quality of the rural population and which may have far-reaching significance for health and vitality is that of migration of rural youths to towns and cities. The period 1930-1940 was a depression decade during which migration from farms to cities was slowed down. Yet between those census dates there was an estimated net movement of 60,000 youths 20-29 years of age in

1940 away from farms in Ohio. This net movement of youths from farms included 33,000 young women and 27,000 young men.

The relative magnitude and importance of the exodus of youths from farms may be judged by comparing the estimated net migration with the youth population enumerated on farms in 1940. If there had been no net loss of youths as a result of migration, the male population 20-29 years old on farms would have been increased by about one-third. The female youth population 20-29 years old would have been increased by one-half.

Counteracting to a considerable extent the net movement of youths away from farms during the thirties was a net movement of older people, 35 years old and over, to Ohio farms. This net movement of older people to farms included 28,000 men and 14,000 women **(Table 4).**

Table 4. Estimated Net Gains and Losses to the Youth and Adult Farm Population Through Migration 1930-1940, by Age and Sex, Ohio

Age period 1940	Both sexes	Male	Female
15 years and over	—27,000	+ 2,000	—19,000
15-19 years	+ 7,000	+ 7,000	....
20-24 years	—17,000	— 9,000	—18,000
25-29 years	—33,000	—18,000	—15,000
30-34 years	— 6,000	— 6,000	....
35-39 years	+11,000	+ 5,000	+ 6,000
40-44 years	+12,000	+ 7,000	+ 5,000
45-54 years	+15,000	+10,000	+ 5,000
55-64 years	+ 4,000	+ 4,000	....
65 years and over	....	+ 2,000	— 2,000

Source: Levels of Living and Population Movements in Rural Areas of Ohio 1930-1940. O.A.E.S. Bulletin 639. March 1943. Appendix table 2, p. 53.

Several studies have shown that migration from farms is selective of youths with better education. That is, the proportion of youths who leave farms is higher for the better educated than for those with more limited schooling. Whether it is also selective with respect to innate intellectual capacities and superior health, is still an open question. In any case, however, the migration is of such character as to bring about more fundamental human losses to the farm population than mere losses in numbers or in manpower.

Marital Status. Another factor which has a bearing on human health is that of marriage and family relationships. It is generally agreed that normal marriage and family living not only provide the physical care for children, but also provide a major source of mental health and happiness both for children and adults.

At the time of the 1940 census there were 39,000 men and 19,000 women living on Ohio farms who were past 30 years of age and who had never married. The bachelors comprised 13.9 per cent of all farm men 30 years old and over, and the spinsters comprised 7.8 per cent of all farm women past 30 years. A little more than 18 per cent of all bachelors past 30 in the State of Ohio lived on farms though only 15.5 per cent of the total population were farm residents. Almost 11 per cent of all unmarried women past 30 lived on farms.[8]

Fertility rates are highest among married women less than 30 years old. In 1940 only 9 per cent of all farm girls 15-19 were married, as were only 51.3 per cent of those 20-24 years old. Just 77.2 per cent of those in their late twenties were married. A total of 10,700 of all farm women in Ohio in 1940 had lived through the entire child-bearing period without being married.

Widowhood is another factor related to mental and physical health. At the time of the 1940 census, a total of 22,600 farm men and 30,300 farm women were widowed. Among the widows 6.8 per cent were still in the child-bearing ages, and among the widowed men 10.2 per cent were less than 50 years old. It is evident from these figures that considerable numbers of farm children are fatherless or motherless in families broken by the death of one or another of the parents.

Divorce is another important index of family disorganization and personal maladjustment. The 1940 census enumerated a total of 95,400 divorced persons in the State of Ohio, of which 41,700 were men and 53,700 were women who reported themselves divorced. These figures probably represent an undercount for, due to the social stigma attached to divorce particularly in rural areas, many persons who are actually divorced report themselves single or in some other marital state. During the period 1930-1940 alone, Ohio courts dissolved 161,600 marriages through divorce. That was about one divorce for each four marriages reported during that same period,[9] and involved a total of 323,200 husbands and wives, and a considerable number of children.

Divorce is often considered an urban problem, but in 1940 there were 7,367 people living on farms in Ohio who reported themselves divorced. Nearly 11 per cent of all divorced men and 5.3 per cent of all divorced women enumerated in the state were living on farms. In the 13 strictly rural counties of Ohio, that is, counties having no center of 2,500 or more population, a total of 352 divorces were granted by the county courts in 1940. Even in these highly rural areas of Ohio there was in 1940 one divorce for each six marriages.

Education. The amount of schooling attained by the population is another indicator of the state of our human resources. The 1940 census presents a picture of the educational status of the adult population. Every man and woman 20 years old and over was asked how much school-

ing he or she had. The answers for Ohio's population 25 years and over are presented in Table 5.

Of all Ohioans 25 years old and over nearly 10 per cent had some college training, and 4.5 per cent had graduated from college. A little more than one-fourth had finished high school including those who had gone on to college. On the other hand 57.8 per cent had not gone beyond the eight grade in school, 8.5 per cent had not gone beyond the fourth grade, including 2.0 per cent who had never gone to school at all. The largest proportion of high school and college graduates was found in the urban areas. On the other hand, the largest proportion of persons with no schooling or with less than five grades was also found in the urban centers.

Table 5. Population 25 Years Old and Over by Years of School Completed by Place of Residence, Ohio 1940

Years of school completed	Number				Per cent			
	The State	Urban	Rural-nonfarm	Rural-farm	The State	Urban	Rural-nonfarm	Rural-farm
Total, 25 and over	4,058,869	2,793,451	680,147	585,271	100.0	100.0	100.0	100.0
No schooling at all.....	82,075	63,319	10,419	8,337	2.0	2.3	1.5	1.4
1–4 years of grade school ...	262,345	189,277	41,301	31,767	6.5	6.8	6.1	5.4
5–8 years of grade school ...	2,000,581	1,272,173	357,536	370,872	49.3	45.5	52.7	63.5
1–3 years of high school	670,750	489,400	109,121	72,229	16.5	17.5	16.0	12.3
4 years of high school	659,232	486,441	102,972	69,819	16.2	17.4	15.1	11.9
1–3 years of college	203,026	147,966	32,870	22,190	5.0	5.3	4.8	3.8
4 or more years of college...	180,860	144,875	25,928	10,057	4.5	5.2	3.8	1.7

Source: Sixteenth Census of the United States, 1940, "Population" Fourth Series Ohio, Table 19, pp. 74-78.

Less than two per cent of the farm population was comprised of college graduates, and only 5.5 per cent had any college training. A little more than 17 per cent of the farm population was comprised of high school graduates, and about 30 per cent had at least one year of high school training to their credit. The majority (63.5 per cent) of adult farm people, however, had from 5–8 years of schooling. A number amounting to 6.8 per cent had no schooling at all, or less than five grades (Table 5).

Due to increased school attendance during the past two generations, younger people at each age level are better educated than their elders. This fact is graphically illustrated in the following table, which shows the percentage of high school graduates in the white population of Ohio and in the farm population of this state at different age periods:[10]

Age	Percentage of H. S. graduates	
	Ohio	Rural-farm
20-24 years	54.3	49.0
25-29 years	46.4	40.2
30-34 years	39.4	31.6
35-39 years	31.1	22.1
40-44 years	25.9	17.6
45-49 years	21.6	14.5
50-54 years	18.3	11.3
55-59 years	16.3	9.3
60-64 years	15.3	8.3
65-69 years	13.1	7.1
70-74 years	11.7	6.3
75 and over	9.8	5.2

From this table it is seen that youths 20–24 years of age are better educated than any other age group. Yet only 54.3 per cent of all young people of that age period had graduated from high school. A little less than one-half (49 per cent) of the farm boys and girls in their early twenties had finished high school at the time of the 1940 census. The proportion of these farm youths who had graduated from high school was, however, about three times as great as that of their parents' generation, and about eight times as great as that of their grandparents' generation.

6. Kiser, Clyde V., "Variations in Birth Rates According to Occupational Status, Family Income, and Educational Attainment", Milbank Memorial Fund Quarterly, Vol. 16, p. 39-56, 1938.

7. Mangus, A. R., and McNamara, R. L., The Rural Youth of Ross County, Ohio: Their Level of Living and Social Achievement, Ohio Agricultural Experiment Station, Wooster, Ohio, Bulletin 635, October, 1942.

8. Sixteenth Census of the United States 1940. "Population" Fourth Series Ohio, Table 7, pp. 13-14.

9. Annual Report of the Secretary of State (Ohio) for the Year Ending December 31, 1940. pp. 140-174.

10. Source: Sixteenth Census of the United States, 1940, "Population" Fourth Series Ohio, Table 19, pp. 74-78.

(To Be Continued)

New Contest for Physician-Artists

To memorialize the medical profession's "skill and courage and devotion beyond the call of duty" is the purpose of the new prize-contest recently announced by the American Physicians Art Association.

The contest is open to all physicians, both civilian and military, who are members of the A.P.A.A. The prizes are sufficiently important to attract some very fine art in all of the principal media, including oil, water color, sculpture, and photography.

For full details, write to the Association's Secretary, Dr. F. H. Redewill, Flood Bldg., San Francisco, Calif.

Zanesville—Methods of removing foreign bodies from the bronchus were discussed by Dr. Robert S. Martin at a meeting of the Kiwanis Club.

Columbus—Dr. Jonathan Forman spoke on the conservation of the human body as well as the soil at a meeting of the Circleville Rotary Club.

Proceedings of The Council

Two Important Meetings Held on September 9 and 10; Report on Industrial Commission Fee Schedule Approved; Pre-election Activities Arranged

MEETINGS of The Council, Ohio State Medical Association, were held in the State Headquarters Office, Columbus, on Saturday evening, September 9, and Sunday, September 10, 1944. The following attended the meetings: President Schriver, President-Elect McNamee, Past-President Sherburne, Treasurer LeFever; Councilors Swartz, Messenger, Noble, Brindley, Dixon, Lincke, Swan, Micklethwaite, Harding, and Knoble; Dr. Forman, Editor of *The Journal*; Dr. Hein, chairman of the Committee on Public Relations and Economics and the Sub-Committee on Workmen's Compensation; Dr. Platter, secretary of the State Medical Board; Executive Secretary Nelson and Assistant Executive Secretary Saville.

On motion by Dr. Brindley, seconded by Dr. Noble, and carried, the minutes of the meetings of The Council held on May 2 and May 4, 1944, were approved.

MEMBERSHIP STATISTICS

The Executive Secretary reported on membership as follows: Total membership as of September 9, 1944—6,741, of which 1,898 were military members; compared to a total membership of 6,780 on December 31, 1943, of which 1,771 were military members.

On motion by Dr. Sherburne, seconded by Dr. Messenger, and carried, The Council authorized continuation during the calendar year 1945 of the present policy providing for waiver or rebate of dues of members entering military or governmental services.

On motion by Dr. Harding, seconded by Dr. Brindley, and carried, the Executive Secretary was authorized to collect 1944 State Association dues from new members on a pro rata basis as follows: Members joining during the period July 1 to October 1, $5.00; physicians joining during the period October 1 to December 31, $3.00.

On motion by Dr. LeFever, seconded by Dr. Micklethwaite, and carried, the Executive Secretary was instructed to send a bulletin to county medical societies, on behalf of The Council, recommending that each county medical society designate a committee or create a new committee to serve as a liaison between the county medical society and members returning from military service and that such bulletin suggest various activities which the committee might undertake.

WORKMEN'S COMPENSATION REPORT

Dr. Hein, chairman of the Committee on Workmen's Compensation, presented to The Council a lengthy report prepared by his committee following seven meetings of the committee held during the Summer. The report recommended recodification of the rules of the Ohio Industrial Commission governing medical services and various changes in the medical and surgical fee schedules. The report, copies of which had been provided members of The Council in advance of the meeting, was discussed and, on recommendation of certain members of The Council and approved by The Council, a number of minor changes in the report were adopted. On motion by Dr. Brindley, seconded by Dr. Knoble, and carried, the report as a whole as amended was unanimously approved and ordered transmitted to the Ohio Industrial Commission for consideration and early action. A letter of transmittal was drafted by The Council. In adopting a motion made by Dr. Lincke, seconded by Dr. Noble, and carried, The Council expressed appreciation to the members of the Committee on Workmen's Compensation for their untiring efforts and excellent report.

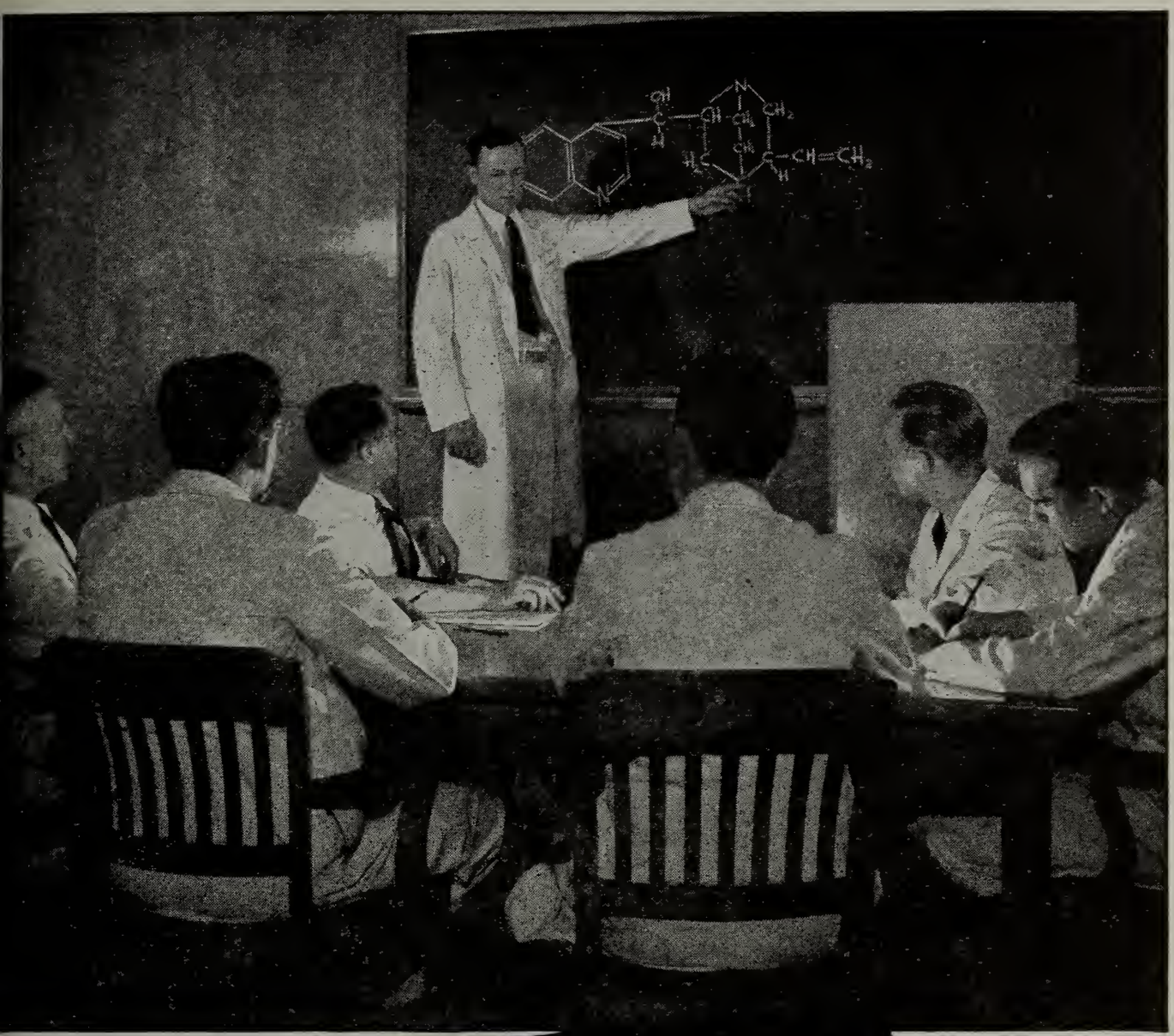
REPORT OF COMMITTEE ON PUBLIC RELATIONS AND ECONOMICS

A lengthy report on a meeting of the Committee on Public Relations and Economics, held in Columbus on Saturday, July 15, was presented to The Council by the Executive Secretary on behalf of Dr. Hein, chairman of the committee.

The committee recommended procedure for obtaining information regarding candidates for public offices to be voted upon at the General Election on November 7 and suggested a plan for the holding of pre-election conferences in each Councilor District to be attended by officers and legislative chairmen of various county medical societies, by The Councilor and by the member of the State Legislative Committee of each district. On motion by Dr. Harding, seconded by Dr. Messenger, and carried, the recommendations of the committee on pre-election activities were approved and the schedule of time and place for the district conferences was agreed upon. The Executive Secretary was instructed to get out the necessary communications and bulletins on this matter as soon as feasible.

WOMEN'S FIELD ARMY

A communication from the Ohio Division of the Women's Field Army for the Control of Cancer with respect to enlargement of the membership of the Executive Board of that organization and asking for an interpretation of the original agreement between the Ohio State Medi-



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cal Association and the Women's Field Army on this matter was considered by The Council, together with the following recommendation from the Committee on Public Relations and Economics:

"It was the sense of the committee that the original agreement between the American Society for the Control of Cancer and the Ohio State Medical Association, adopted by the State Association on April 27, 1937, with respect to the makeup of the Executive Committee of the Women's Field Army in Ohio, should be modified. It was pointed out that the Executive Committee of the Women's Field Army has found it necessary to expand its personnel in order to attract the interest of influential groups and individuals and that in doing so there has been a technical violation of the agreement which provides for an Executive Committee of five, three of whom shall be physicians named by The Council of the State Association, one of whom shall be the Director of Health, and one of whom shall be a representative of some reputable woman's organization. In expressing itself that this setup is no longer workable and should be changed, the committee, on **motion** by Dr. Sherburne, seconded by Dr. McNamee and **carried**, adopted the following statement as a recommendation to the Women's Field Army with regard to the makeup of the Executive Committee:

> " 'That in the future a majority of the members of the Executive Committee, Ohio Division, Women's Field Army, American Society for the Control of Cancer, shall at all times be doctors of medicine approved by the Ohio State Medical Association.'

"It was the understanding of the committee in taking this action, first, that the Ohio State Medical Association would not necessarily be asked to approve appointments to the Executive Committee of individuals other than doctors of medicine; and, second, that it would not necessarily be the responsibility of the Ohio State Medical Association to select the physicians for the Executive Committee but only to approve names which might be suggested. It was understood, however, that at all times, as the statement indicates, a majority of the active members of the Executive Committee shall be doctors of medicine having the endorsement of the State Association."

On **motion** by Dr. Swartz, seconded by Dr. Micklethwaite, and **carried**, the recommendations of the committee as set forth above were **approved.**

POLICY ON DIAGNOSTIC CLINICS

The committee then reported that it had also considered a proposal from the Executive Committee of the Women's Field Army regarding the establishment of diagnostic clinics and that the committee recommended to The Council that the proposal be approved by The Council, providing the establishment of such clinics is carried out in line with the following excerpt from the minutes of a meeting of the Executive Committee of the Women's Field Army held in Cincinnati on April 30, 1944:

"A great deal of discussion was entered into regarding the establishment of diagnostic clinics, particularly for communities in which there are no hospitals and for those persons who cannot pay full cost of an examination by a specialist at some distant point. This type of clinic would really be an examination by a specialist who would be invited to a particular community by the local medical society and who would examine cases brought in by private physicians or the physicians in charge of an indigent case. Each person would pay what he was able toward the cost of an examination and the Women's Field Army would make up the difference between the income and total cost. A fee would be agreed upon with the specialist. Those cases who needed X-ray or pathology would be referred to proper centers and if there were no funds for transportation and for examinations at these centers, the Women's Field Army could be responsible. If such an examination clinic is held in a county which has retained its share of membership fees, such local organization would be expected to contribute toward the cost. Local medical societies to choose the specialist to be invited and if they have no choice, then a list of specialists prepared by the Executive Committee of the Women's Field Army and approved by the Ohio State Medical Association is to be provided local societies for their choice."

On **motion** by Dr. Swartz, seconded by Dr. McNamee, and **carried**, the foregoing recommendation of the committee was **approved.**

LITERATURE ON CANCER

A proposal from the Women's Field Army, submitted to the Ohio State Medical Association for consideration, which would provide for the printing and distribution to the public of a single sheet presenting the early signs and symptoms of cancer, and Dr. Adair's ten golden rules for doctors to follow in making a medical examination, was then considered.

The Committee on Public Relations and Economics reported that it had given careful study to this proposal and that it recommended to The Council **that the proposal not be approved as submitted.** The committee pointed out that it felt it would be unwise to provide the laity with blanks carrying information as to how a physician should conduct his examination and which matters would be entirely medical procedures. The committee stated that it believed it would be entirely proper for the Women's Field Army to distribute to the public literature regarding the symptoms and signs of cancer. It was the suggestion of the committee that the proper committee of the Ohio State Medical Association prepare an article on what should be included in a complete cancer examination and that such an article should be published at least three times a year in *The Ohio State Medical Journal* for the information of all Ohio physicians.

On **motion** by Dr. Swartz, seconded by Dr. Sherburne, and **carried**, the recommendations of the committee disapproving the proposal as sub-

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mitted, but approving the specific recommendations made by the committee as to how the same objectives could be obtained were **approved.**

OTHER ACTIVITIES OF COMMITTEE

Suggestions made by the Committee on Public Relations with respect to the adoption of a statement of policy on current publicity being given to rapid treatment methods for syphilis were discussed at length. Action on the preparation of such a statement was deferred until the next meeting of The Council, on **motion** by Dr. Sherburne, seconded by Dr. Dixon, and **carried.**

The committee reported that it had prepared a special bulletin which has been sent to county medical societies, urging such societies to request Ohio members of Congress to support the Miller Bill, H. R. 5128, which would direct the Selective Service to defer a certain number of medical and premedical students annually.

POLICY ON PROPOSAL CONFIRMED

The committee reported on action which had been taken on communications received from the American Medical Association and Senator Harold H. Burton of Ohio pertaining to a Congressional bill setting forth how the Department of Agriculture should use funds for medical care programs for low-income farmers. The committee stated it had informed Senator Burton that it was the general policy of the Ohio State Medical Association on medical care programs that the patient should have free choice of physician. On **motion** by Dr. Swartz, seconded by Dr. Harding, and **carried,** this action of the committee was unanimously **approved** by The Council and the Executive Secretary was instructed to advise the American Medical Association of the action taken and why.

For the information of The Council the committee submitted certain data with respect to developments on the emergency maternity and infant care program operating under the United States Children's Bureau; sickness disability insurance; Blue Cross Hospital Service Plans proposals; physical fitness and recreation; procedures for the taking of X-ray chest plates in tuberculosis case findings programs, etc. The committee made no specific recommendations at this time on these subjects, but stated that they are being studied and will be covered in a supplemental report to The Council at another meeting.

ANNUAL MEETING

After hearing a financial report on the 1944 Annual Meeting, held in Columbus, May 2, 3 and 4 and receiving letters of appreciation from Mrs. Schriver and Mrs. Sherburne for flowers sent to them at that time by The Council and a communication from Mr. Grove Patterson who was the banquet speaker, The Council then discussed the question of time and place for the 1945 Annual Meeting. After thorough consideration, on **motion** by Dr. Knoble, seconded by Dr. Noble, and **carried,** The Council selected the Neil House, Columbus, for the 1945 Annual Meeting and the dates Tuesday, Wednesday and Thursday, May 1, 2 and 3.

DEVELOPMENTS ON MEDICAL SERVICE PLANS

A report on meetings of the Committee on Medical Service Plans, held on July 15 and August 20, 1944, was presented for consideration of The Council.

The committee stated that a communication had been received from the Logan County Medical Society to the effect that the Logan County Medical Society has rejected a proposal to operate an all-inclusive prepayment plan in Logan County for rural citizens. The committee recommended to The Council that The Council express to the Logan County Medical Society its regret at the action taken by the society but to inform the society that the Committee on Medical Service Plans stands ready to help that society in any future deliberations it might have on this subject. On **motion** by Dr. McNamee, seconded by Dr. Swartz, and **carried,** the recommendation of the committee was **approved** and the Executive Secretary was instructed to write the Logan County Medical Society accordingly.

A recommendation of the Committee on Medical Service Plans, that The Council commend the efforts of the public policy committee of the Greene County Medical Society in preparing a proposed medical service plan for that county, was **approved** on **motion** by Dr. Brindley, seconded by Dr. Knoble and **carried.** The motion carried the statement that the State Association would be very glad to assist the Greene County Medical Society in working out details of the plan, if request for assistance is received from the Greene County Medical Society.

CONFERENCES WITH BLUE CROSS

The committee reported that it is engaged in a series of conferences with representatives of the Cincinnati and Columbus Blue Cross Plans on matters pertaining to the possibility of organizing a mutual insurance company to provide subscribers of Blue Cross Plans with surgical and obstetrical indemnity benefits. The committee stated that this question had been discussed at meetings of the committee on July 15 and August 20 and that another meeting has been scheduled for September 17.

Reference was made in the report to a bulletin recently issued by the Advisory Council of the Ohio Farm Bureau inferring that efforts may be made at the next session of the Ohio Legislature to amend House Bill 51, the Ohio Enabling Act



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for medical service plans which was sponsored by the Ohio State Medical Association.

The committee also reported that it had expressed a deep interest in an experiment being carried on in Toledo to provide employed individuals with surgical and obstetrical indemnity coverage under a plan worked out between the Toledo Academy of Medicine and a casualty insurance company.

A supplemental report on matters referred to and other questions being considered by the committee was promised.

MISCELLANEOUS QUESTIONS

There was a general discussion of vacancies now existing on the State Medical Board and the Ohio Public Health Council.

The following appointments to State Association committees were made by President Schriver and **approved** on **motion** by Dr. Sherburne, seconded by Dr. Brindley, and **carried:**

> Dr. James G. Kramer, Akron, as a member of the Committee on Public Relations and Economics, succeeding Dr. O. J. Walker, Youngstown, resigned.
>
> Dr. John A. Caldwell, Cincinnati, as chairman of the Judicial and Professional Relations Committee, of which he is now a member, succeeding Dr. Kramer who resigned as a member of that committee to accept the appointment on the Committee on Public Relations and Economics.
>
> Dr. Azel Ames, Jr., Hamilton, as a member of the Committee on Medical Service Plans.

The Council authorized deletion of the name of Mr. J. L. Price, Youngstown, as an ex officio member of the committee, inasmuch as Mr. Price is no longer connected with the Medical-Dental Bureau of Youngstown.

Dr. Schriver announced that he would submit a recommendation for a successor to Dr. Kramer on the Judicial and Professional Relations Committee at the next meeting of The Council, and he requested members of The Council to submit suggestions to him in the interval.

HEALTH BLANK DRAFTED

A communication from Mr. Paul E. Landis, Supervisor of Health, Physical Education, Recreation and Safety, Ohio Department of Education, requesting the cooperation of the Ohio State Medical Association on a school and community health education project of the Department of Education, was read and discussed. On **motion** by Dr. Lincke, seconded by Dr. Noble, and **carried,** The Council voted its cooperation and assistance and suggested to the Executive Secretary that he bring this to the attention of county medical societies in an early bulletin.

A request from Mr. Landis of the Ohio Department of Education for assistance in compiling a blank to provide for a school health record and medical examination for school children was considered. Suggestions received from Dr. Carl A. Wilzbach, Cincinnati, chairman of the Committee on Public Health Education, were reviewed and material for such a blank for submission to Mr. Landis was **approved** on **motion** by Dr. LeFever, seconded by Dr. McNamee, and **carried.**

At this point Mr. C. B. Craig of Cincinnati, Director of the Committee on Publications for Ohio of the Christian Science Church, appeared before The Council to discuss the possibility of working out with the Association an agreed bill on legislative matters of interest to the Christian Science Church. Following his remarks, Mr. Craig was requested by The Council to submit specific suggestions for consideration by The Council at its next meeting.

JOURNAL ADVERTISING RATES

The Editor of *The Journal,* Dr. Forman, and the Executive Secretary presented a memorandum suggesting increases in the advertising rates of *The Journal.* After a thorough discussion, on **motion** by Dr. Swan, seconded by Dr. Dixon, and **carried,** the recommendations of the Editor and the Executive Secretary on increasing advertising rates, to be effective January 1, 1945, were **approved.**

A communication from Dr. L. A. Pomeroy, chairman of the Executive Committee of the Women's Field Army for the Control of Cancer, asking for the approval of the Ohio State Medical Association on the appointment of Mrs. Whiting Williams, Cleveland, as a member of the Executive Committee of that organization, was read. On **motion** by Dr. McNamee, seconded by Dr. Lincke, and **carried,** The Council **approved** the contemplated appointment.

Communications from the Surgeon General of the United States Army, Surgeon General of the United States Navy, and the Director of the Veterans' Administration, furnished at the request of the Association and setting forth the policy of those agencies with respect to medical officers and officers at Veterans' Administration Facilities engaging in private practice or acting as consultants, were read. These communications were ordered filed for future reference, if necessary.

A communication from an insurance company with respect to a retirement plan for employes of the State Association was referred to the Committee on Auditing and Appropriations for investigation and report.

A communication from the Ohio State Nurses'



No food (except breast milk) is more highly regarded than Similac for feeding the very young, small twins, prematures, or infants who have suffered a digestive upset. Similac is satisfactory in these special cases simply because it *resembles breast milk so closely,* and normal babies thrive on it for the same reason. This similarity to breast milk is definitely desirable — *from birth until weaning.*

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Association pertaining to an outline of personnel practices and entrance salaries for nurses was discussed. No action was taken pending further consideration.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

Toledo University Postgraduate Day Scheduled for November 3

Ohio physicians are cordially invited to attend the Eleventh Annual Postgraduate Day of the Medical Institute of the University of Toledo, which will be held at Toledo University, Friday afternoon and evening, November 3.

The lecturers will be: Col. Joseph C. Bell, M.C., Percy Jones General Hospital, Battle Creek, Mich.; Col. B. R. Kirklin, M.C., chief consulting roentgenologist, Office of the Surgeon General, U. S. Army; Dr. U. V. Portmann, radiologist, Cleveland Clinic, and Dr. Lawrence Reynolds, Detroit, editor-in-chief, *American Journal of Roentgenology and Radium Therapy.*

The session will begin at 3:30 o'clock, with Dr. Barney J. Hein, Toledo, as chairman. After greetings by Dr. H. H. M. Bowman, professor of biology, University of Toledo, the following program will be presented: "Roentgenographic Chest Studies as Seen in the Percy Jones Hospital", Col. Bell; "The Place of the Cholecystogram in the Diagnosis of Gall Bladder Disease", Col. Kirklin; "Irradiation in Cancer of the Breast", Dr. Portmann.

President Phillip C. Nash, of the University will preside at the Memorial Dinner, scheduled for 6:30, at which Dr. Edgar P. McNamee, Cleveland, President-Elect of the Ohio State Medical Association, will bring greetings from the Association.

Dr. E. B. Gillette, Toledo, will be chairman at the evening session, beginning at 8 o'clock with a memoriam to the late Dr. John T. Murphy by Dr. F. M. Douglass, Toledo. Scientific addresses at this session will be: "Pseudo Fractures and Some Medical Legal Problems in Connection with General Practice", Dr. Reynolds; "Rupture of the Intervertebral Disc, with Extrusion of a Portion of the Disc Into the Spinal Canal, as a Cause of Low Back and Lower Extremity Pain", Col. Bell; Gastro-Intestinal Conditions Revealed by X-ray", Col. Kirklin.

The committee on arrangements for the postgraduate day consists of: W. W. Alderdyce, M.D.; H. H. M. Bowman, Ph.D.; F. M. Douglass, M.D.; E. B. Gillette, M.D.; Barney J. Hein, M.D.; Dale Wilson, M.D.; and Phillip C. Nash, D.Sc.

Sulfonamides Are of No Value in Treatment of Poliomyelitis

The sulfonamide drugs are of no value in the treatment of infantile paralysis and physicians should be warned against their use for this disease, John A. Toomey, M. D., Cleveland, declares in a letter published in *The Journal of the American Medical Association* for September 2. Dr. Toomey says:

"I feel that physicians should be warned against the use of sulfonamide drugs in the treatment of poliomyelitis.

"It has been noticed clinically that when paralyses of the intestine and urinary bladder persist there are apt to be extensions of the . . . paralyses. When urinary retention was produced in animals (monkeys) by the use of sulfonamide compounds, drugs which produced ureliths (kidney stones) and blockage of the ureters (urinary passages), a more massive disease was produced two or three days sooner than that which appeared in controls simultaneously injected with poliomyelitis virus.

"Rosenow had the same experience with sulfapyridine at the Mayo Clinic and reported that this drug produced an additive neurotoxic (poisonous effects on the nerves) effect.

"Recently an explosive epidemic of poliomyelitis occurred in a small town of Northern Ohio. The number of patients that developed severe paralysis seemed out of proportion to the normal expectancy. Most of these patients had received sulfonamide drugs (information received from Mrs. Louise Bowers, health officer, Perrysburg, Ohio).

"Recently a 12 year old girl had signs of meningeal irritation (of the membrane enveloping the brain and spinal cord), but no sign of any muscle involvement save in one leaf of the soft palate. The reflexes were hyperactive; the child was not acutely ill. . . . The prognosis seemed good whether the condition was poliomyelitis or meningitis. Sulfadiazine was started. Twelve hours later and after 12 Gm. of sulfadiazine had been given, a massive extension of paralysis suddenly developed, the throat muscles and intercostals (muscles between the ribs) all becoming affected within an hour. This sudden explosive extension in an otherwise nearly normal patient had not been our previous experience in this type of case.

"The sulfonamide drugs are of no value in poliomyelitis. Nor does penicillin help much in our experience, although we have not noticed that it does any harm."

Mansfield—A $125,000 addition to Mansfield General Hospital, started last April, will be completed late this Fall and will provide accommodations for about 30 more patients.

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OCTOFOLLIN is effective in relieving menopause symptoms, senile vaginitis and may be used in the treatment of infantile gonorrheal vaginitis, in suppression of lactation and in ovarian hypofunction of estrogenic origin.

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Planks on Public Health and Medical Care In Platforms Adopted by Ohio Democrats and Republicans

RESOLUTIONS on public health and medical care were inserted in the platforms adopted at the recent state conventions of the Democratic and Republican parties held in Columbus. The texts of the planks are presented below for the information of Ohio physicians:

DEMOCRATIC PLANK

We believe a paramount responsibility of good government is to be the protection and improvement of the public health. Therefore, we pledge maintenance of the Department of Public Health by an able and competent staff selected and retained on the basis of merit and supported by a state-wide health council; fullest cooperation with Federal and county health authorities in the expansion of the services of the department, and in maintaining the highest standards of public health service.

REPUBLICAN PLANK

Within the past five years, Ohio has adopted legislation to permit groups, particularly those people with limited incomes to secure adequate hospital and medical care of high quality at low cost.

We pledge ourselves to cooperate with and encourage such groups to the end that the availability of this care may greatly be expanded.

We are unalterably opposed to the destruction of the doctor-patient relationship or the acceptance of a program of socialized medicine.

Survey of Hospital Facilities and Needs To Be Headed by Dr. Bachmeyer

Dr. A. C. Bachmeyer, director of the University of Chicago Clinics, formerly of Cincinnati, has been appointed to conduct a two-year survey of America's hospital system by the Commission on Hospital Care of the American Hospital Association. It will be an independent, unbiased study to serve as a basis for plans for future hospital facilities and the extension of those already in service. Dr. Bachmeyer will make a survey of hospital facilities in three states—California, Michigan, and one in the South—to determine the health needs of every segment of the population, and to investigate the potentialities for an even wider distribution of hospital service.

On the basis of these studies, a nation-wide plan looking toward greater co-ordination among hospitals will be developed, aimed at extending hospital care of the sick and injured to all—the farmer, the laborer, the urban dweller, and those groups requiring specialized attention for mental and incurable diseases.

Dr. Thomas S. Gates, president of the University of Pennsylvania, is chairman of the Commission, which has been financed by a fund of $105,000 contributed by the Kellogg Foundation, the Commonwealth Fund of New York, and the National Foundation for Infantile Paralysis.

Osborn—Dr. and Mrs. C. W. Miller recently celebrated their golden wedding anniversary.

Tuberculosis Control Division Set Up By U.S. Public Health Service

Under authority given Surgeon General Thomas Parran by the Public Health Service Act of 1944 recently enacted by Congress, a Tuberculosis Control Division has been established in the U.S. Public Health Service, Federal Security Agency. Dr. Herman E. Hilleboe, who has been in charge of the U.S.P.H.S. tuberculosis control activities since 1942, was named chief of the new division. Dr. R. L. Thompson is head of the Public Health Service's Bureau of State Services, within which the division will operate.

In announcing the formation of the new unit, Dr. Parran said that it will be able to conduct a program for tuberculosis control comparable to the national program for venereal disease control, when Congress appropriates the $10,000,000 already authorized.

Functions of the division include:

1. Developing more effective measures for the prevention, treatment, and control of tuberculosis.

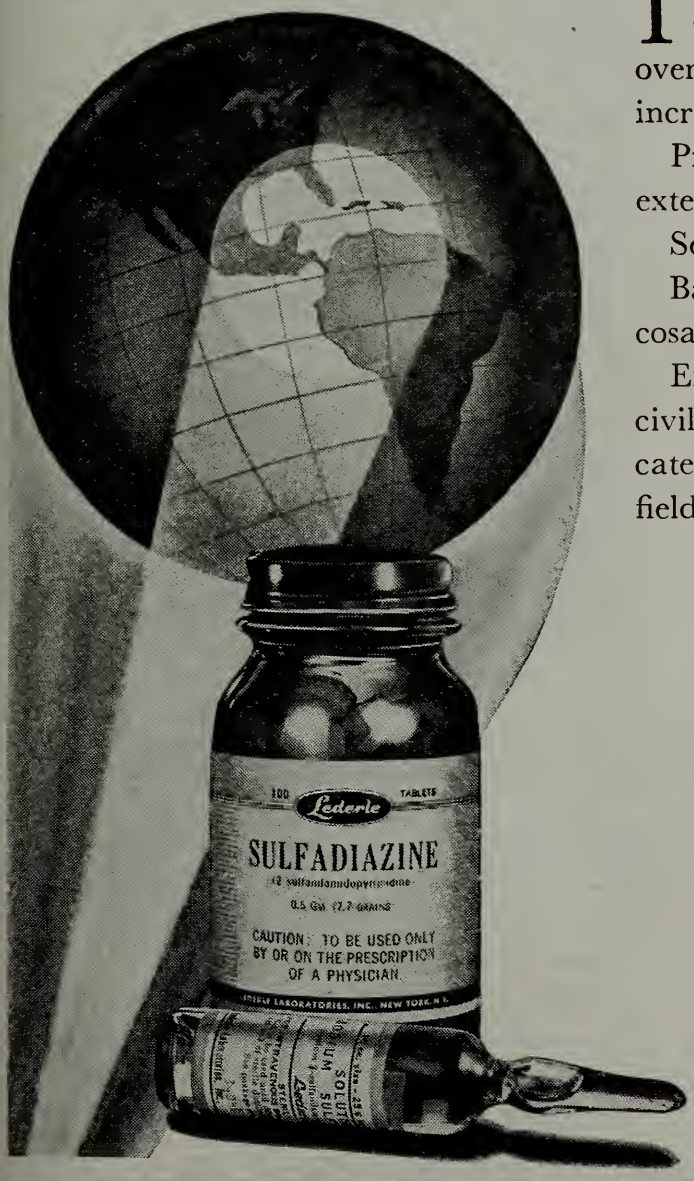
2. Assisting states, counties, health districts, and other political subdivisions of the states in establishing and maintaining adequate measures for the prevention, treatment, and control of tuberculosis.

3. Preventing and controlling the spread of tuberculosis in interstate traffic, and any other activities with respect to the prevention, treatment, and control of tuberculosis that may be authorized to be performed by the Public Health Service.

Bacillary dysentery—

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IN THE CONTROL of acute bacillary dysentery, SULFADIAZINE presents certain advantages over the other sulfonamides that have gained increasing recognition.

Prolonged high blood levels tend to prevent extension of the infection.

Secretions in the gut become bacteriostatic.

Bacterial growth within the intestinal mucosa tends to be inhibited.

Extensive clinical experience in military and civilian practice supports these views and indicates increasing use of SULFADIAZINE in this field.

REFERENCES:

HARDY, A. V.; BURNS, W. and DE CAPITO, T.: Pub. Health Rep. 58: 689 (Apr. 30) 1943.

HARDY, A. V. and CUMMINS, S. D.: Pub. Health Rep. 58: 693 (Apr. 30) 1943.

HALL, W. W.: Am. Drug Mfgrs. Assoc., Annual Convention, Scientific Sec., Hot Springs, Va., May 1, 1944.

Annual Reports, U. S. Pub. Health Service, 1942-43, p. 122.

PACKAGES:

Sulfadiazine Tablets, 0.5 Gm. (7.7 grains) each (grooved) Bottles of 50, 100, 1000, 5000 and 10,000 tablets.

Solution Sodium Sulfadiazine (sodium 2-sulfanilamido-pyrimidine) 25% w/v solution.

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Digest of New Provisions of E.M.I.C. Program for Wives and Infants of Service Men and Required Procedures

IN order to bring Ohio physicians up to date on the provisions of the program of the U. S. Children's Bureau for the Emergency Maternity and Infant Care of the Wives and Children of enlisted men in certain grades, *The Journal* requested Dr. Susan P. Souther, Chief, Division of Child Hygiene, State Department of Health, the agency which administers the program in Ohio, to outline the principal features of the plan. A detailed description of the program appeared in the September, 1943, issue of *The Journal*, pages 850-853. Questions and answers pertaining to it were published in the October, 1943, issue, pages 939-943, and announcement of an increase in fees was made in the May, 1944, issue, pages 448-449.

While most Ohio physicians are familiar with the administrative features of the program, the accompanying digest prepared by Dr. Souther should be helpful as reference material. Adherence to the rules as outlined will minimize misunderstandings and delays.

I. Eligibility for care under program:

Wives and infants of enlisted men in the 4th to 7th pay grades of the U. S. Army, Navy, Marine Corps, or Coast Guard or of Army aviation cadets are eligible for care under the program. If the enlisted man is discharged or promoted after care has been authorized, the wife or infant can continue to receive services available under the program. Application for care may be made by a wife or in behalf of the wife or infant of an enlisted man of the aforesaid grades, who is listed as missing in action or deceased.

If additional information is desired regarding eligibility, the patient or physician may write to the State Department of Health.

II. Conditions under which services may be authorized:

1. The individual for whom services are authorized must be the wife or infant of an enlisted man in the 4th to 7th pay grade or of an Army Aviation cadet.
2. There shall be no financial investigation to determine eligibility.
3. The individual applying for care shall have free choice of all types of available facilities and services that meet the standards established under the State plan for each type of service or facility.
4. The attending physician has the qualifications and the hospital meets the standards established under the State plan.
5. The attending physician has agreed to accept payment only from the State Health Department for whatever services he renders and for which authorization has been issued under the State program.
6. The hospital, if hospital care is requested, has agreed to accept payment only from the State Health Department for services rendered during a period of authorized hospital care under the program.
7. Physicians' services will not be authorized if the patient or someone in behalf of the patient is to pay for hospital care; and hospital care will not be authorized if the patient or someone in behalf of the patient is to pay the physician for medical care.

III. Application and authorization for care:

Applications for care must be made out on forms supplied by the State Department of Health. Copies of these forms can be obtained from local health departments or by writing directly to the State Department of Health, State Office Bldg., Columbus. These forms must be made out by the wife, or by someone acting in behalf of the infant, and by the physician. Application for maternity care should be made promptly, if possible, at the time of the first visit to the physician, clinic, or hospital. When an application is submitted after delivery or some time after a child has been ill, the application must be accompanied by a statement as to why the application is late. Care will only be authorized in such cases when there is a valid reason for delayed application.

The wife, or other person acting in behalf of the infant, should enter on the application form the date when care for herself or her infant is requested to begin. This item will be on new application forms which will soon be released. The physician should also enter on the application form the date on which he wishes payment for care to begin. The dates given by the patient and physician should agree.

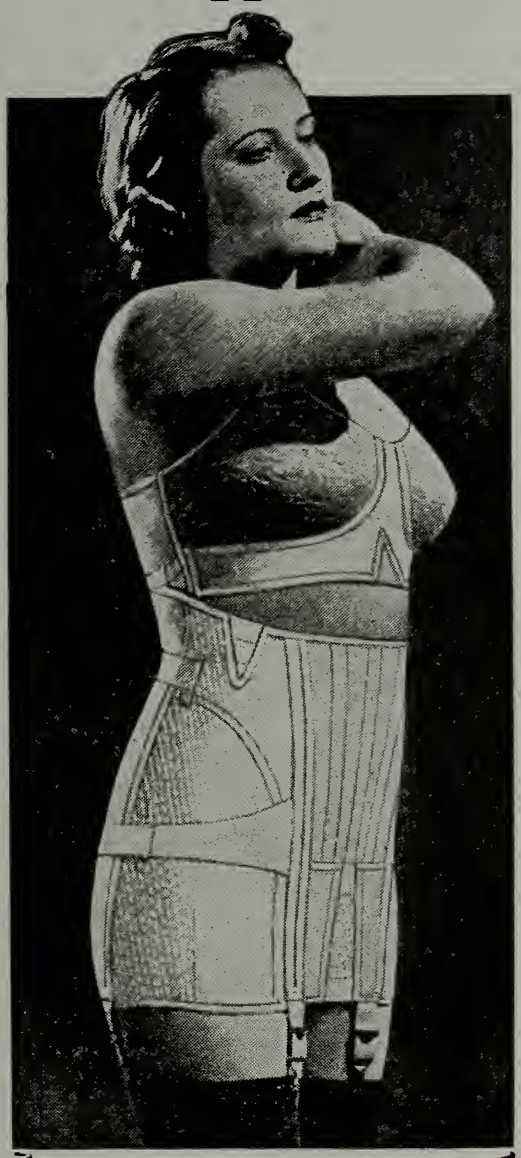
After being properly filled out and signed, application forms should be mailed to the Division of Child Hygiene, State Department of Health, State Office Building, Columbus.

IV. Services that may be authorized:

A. Medical and hospital services for the wife:

1. **Complete maternity care.** Complete maternity care, that is, care for the mother during pregnancy, labor and until the end of the six weeks postpartum period, and for the infant during the first two weeks of life, may be authorized not to exceed $50. This maximum payment of $50 will

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be provided as follows: a maximum of $15 for prenatal care at $2 per office or hospital visit and $3 per home visit; $30 for delivery; and $5 for the postpartum examination six weeks after delivery.

When an obstetrician refers an infant to a pediatrician for routine care during the first two weeks of life, no reduction will be made in the rate of payment to the obstetrician for "complete maternity care".

In exceptional cases, additional payment for additional hospitalization and payment for medical care may be authorized for continuing care of the mother beyond six weeks postpartum, for a serious complication of pregnancy. When such additional payment is made, the rate of payments for visits will be made not to exceed $24 for the first three weeks of illness, and for succeeding weeks of illness not to exceed $6 per week. The maximum rate of payment will be $3 for a home visit, and $2 for a hospital visit.

2. **Major non-obstetric intercurrent surgical operations.** Additional payments may be authorized to attending physicians who qualify as consultants in a surgical specialty, for major, non-obstetric surgical operations needed during pregnancy and six weeks postpartum for conditions not attributable to pregnancy (such as appendectomy) at a rate of $50 for pre-operative, operative and post-operative care.

3. **Medical care of other intercurrent non-obstetric conditions.** Additional payment for medical care (for a period of three weeks, with review by the State Health agency before authorization of an extension of care) may be authorized during pregnancy and six weeks postpartum for the home or hospital treatment of intercurrent conditions not attributable to pregnancy, which do not require major surgery, at a rate of payment not to exceed $24 for the first three weeks of such illness, and for succeeding weeks not to exceed $6 per week. The maximum rate of payment will be $3 for a home visit, and $2 for a hospital visit.

4. **Prenatal care only, or spontaneous abortion.** When only prenatal care is provided by the attending physician, the rate of payment will not exceed $15 at a rate of $2 per office or hospital visit, and $3 per home visit.

   If pregnancy terminates in spontaneous abortion not requiring an operation, the rate of payment will be $15 plus payment at the usual rate allowed for such prenatal care as may have been given.

5. **Care of newborn infant by pediatrician.** Routine care of newborn infant for first two weeks by a qualified pediatrician when the obstetrician does not customarily provide routine care for infants at a rate not to exceed $6 a week. If fewer than 3 visits a week to the infant are made by the pediatrician, payment will be made at the rate of $2 per visit for services rendered.

6. **Hospital Care.** Hospital care may be authorized for a period of two weeks. Extension of hospital care for periods of two weeks may be authorized after review of the case by the State Health agency.

B. Medical and hospital care for the infant:

1. **Medical care for sick infants, including minor surgery.** The weekly rate of payment for medical care, including minor surgery, will be at a rate not to exceed $24 for the first three weeks of illness, and for succeeding weeks of illness after the first three weeks, not to exceed $6 per week. The maximum payment for a home visit is $3, and for an office or hospital visit $2. Extension of care for three-week periods may be made after review of the case by the State Health agency.

2. **Major surgery.** Additional payment may be authorized by the State Health agency to attending physicians who qualify as consultants in a surgical specialty, for major surgical operations performed on infants under their care (exclusive of care for which infants are eligible under the State Crippled Children's program); at a rate of $50 for pre-operative, operative and post-operative care.

3. **Hospital care.** Hospital care for sick infants will be authorized for periods of three weeks. Extension of hospital care for periods of three weeks may be authorized after review of the case by the State Health agency.

4. **Immunization.** No provision is made for paying the attending physician for immunization of the infant.

C. Consultation, nursing, or other services for the wife or infant:

1. **Bedside consultation or assistance, or minor surgery.** A qualified specialist will be paid a fee of $10 for consultation or assistance. Additional consultations may be authorized after review of the case. Request for authorization for consultation should be made as soon as convenient after the service is given. The attending physician may make the request for consultation by telephone or by letter. He should give the name of the consultant called, should state the reason for the consultation, and should state



Constipation probably is encountered more frequently than any other condition the physician is called upon to treat.

A new method of treatment is "Smoothage" as provided by Metamucil. With "Smoothage" the need for harsh cathartics or intestinal irritants is obviated.

METAMUCIL is a highly purified, non-irritating extract of a seed of the psyllium group, Plantago ovata (50%), combined with dextrose (50%). It provides gentle physiologic impulses which activate peristalsis.

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the type of service performed by the consultant.

2. **Consultation which includes performance of a major or intermediate surgical operation by a consultant.** A qualified specialist will be paid a fee of $50 for care rendered in connection with a major surgical operation. A qualified specialist will be paid a fee of $25 for an intermediate surgical operation. (Major surgical procedures include: Cesarean section, appendectomy, pyloric operation, operation on spina bifida. Intermediate surgical procedures include: difficult forceps, version and extraction for a mother; treatment of birth marks, treatment of extensive burns for an infant.)
3. **Nursing services.** The following types of nursing service by an Ohio registered nurse may be provided: special nursing service during a period of critical illness; home delivery nursing service; nursing care of mother and infant during the puerperium by a nurse from a visiting nurse association or by an Ohio registered nurse. Information regarding rates of payment for nursing services and the periods for which nursing care may be authorized will be supplied by the Ohio Department of Health on request.
4. **Blood for transfusions.** Blood for transfusions may be authorized at the customary minimum rate paid by the hospital for blood. A maximum rate of $25 will be authorized for blood or plasma for each transfusion.
5. **Ambulance service.** Ambulance service for emergencies only will be paid at the prevailing local rate, with a maximum of $10 for ambulance service.
6. **Unusually expensive drugs.** Unusually expensive drugs may be authorized not to exceed the cost of the drugs.
7. **Authorization for care of prolonged illness.** For cases of prolonged illness, medical and hospital care may be authorized for a period of two months. If additional care is needed, extension of care for one-month periods may be given after review of the case.

Surgeons Assembly Cancelled

The American College of Surgeons has cancelled its Annual Clinical Congress because of the acute war situation that has developed, involving greater demands than at any time in the past upon transportation systems for the carrying of wounded military personnel, troops, and war materiel. The Congress was to have been held in Chicago, October 24 to 27.

If You Move, Advise Us at Once of Your New Address

IF you change your address, please notify *The Journal* promptly. The deadline for address changes for each issue is the 15th day of the month preceding date of publication, i.e., 15th day of October for the November 1 issue. If you move, therefore, the only way to be sure of getting your *Journal* regularly is to send your new address in immediately.

If your *Journal* is late in reaching you these days, be patient. The mails are clogged and there is a shortage of labor at our print shop. Wait until the 15th of the month before assuming your *Journal* has gone astray. If you don't get it by then, drop us a line and we will mail you a copy if extra copies are available.

Movies on Neuropsychiatry Made Available for Medical Groups

A series of motion picture films on neuropsychiatric disorders have been made available to medical and strictly scientific groups for educational purposes by a new department of medical films in the New York University Film Library.

The series of eleven films are the work of Dr. S. Philip Goodhart, chief of the neuropsychiatric division of Montfiore Hospital, New York, and professor of clinical neurology at Columbia University; and Major Benjamin Harris Balser, M. C., consultant in neuropsychiatry, First Aid Forces, and associate in neurology at Columbia University.

New Winthrop Company Executive

Appointment of Dr. Martin Lasersohn as assistant to the president, and his election as assistant treasurer of Winthrop Chemical Company, Inc., has been announced by Dr. Theodore G. Klumpp, president. Dr. Lasersohn has also been elected secretary of Fairchild Bros. & Foster, a Winthrop subsidiary. Prior to assuming these executive duties, Dr. Lasersohn was medical director of Winthop Chemical Company, with whom he has been associated since 1930. From 1928 to 1930 he was associate professor of medicine at the Medical College of Virginia, Richmond, Va. Dr. Lasersohn received his B.S. at Washington University, St. Louis, and his M.D. at its School of Medicine in 1922.

Youngstown—Dr. Edgar C. Baker gave a talk on X-ray at a meeting of the Kiwanis Club.



ANOURISHING ration for all infants and one that is well tolerated by those of premature birth.

Years of use, under physicians' directions, prove the value of Baker's Modified Milk either complemental to or entirely in place of human milk, starting at birth and continuing through the bottle-feeding period. Baker's is well supplied with the nutritive elements for normal growth and is fortified with seven dietary essentials, including liberal protein content (60 per cent more than human milk).

Physicians favor Baker's Modified Milk because it is particularly useful in difficult feeding cases . . . helps to discourage regurgitation and to correct loose or too frequent stools, especially when acidified.

Mothers like the convenience of Baker's Modified Milk—keeps well, without refrigeration...easy to use both at home and when traveling because Baker's is available in powder and liquid form. For feeding, it is diluted to the prescribed strength with cool water, previously boiled.

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Military Roster of Association Approaches 3,000 Mark; Names Added, Promotions and Breakdown by Counties

As of September 19, the Military Roster of the Ohio State Medical Association totaled 2,973, after readjustments for additions to and separations from the services. Of the total number if Ohio physicians in the services, 2,503 are in the Army, 400 in the Navy and 71 in miscellaneous full-time government services. Following are the names added to the Military Roster during the past month, those promoted and a breakdown of the roster by counties. The star (*) indicates that the physician has been in the service for some time but that this information has just been received by the Association.

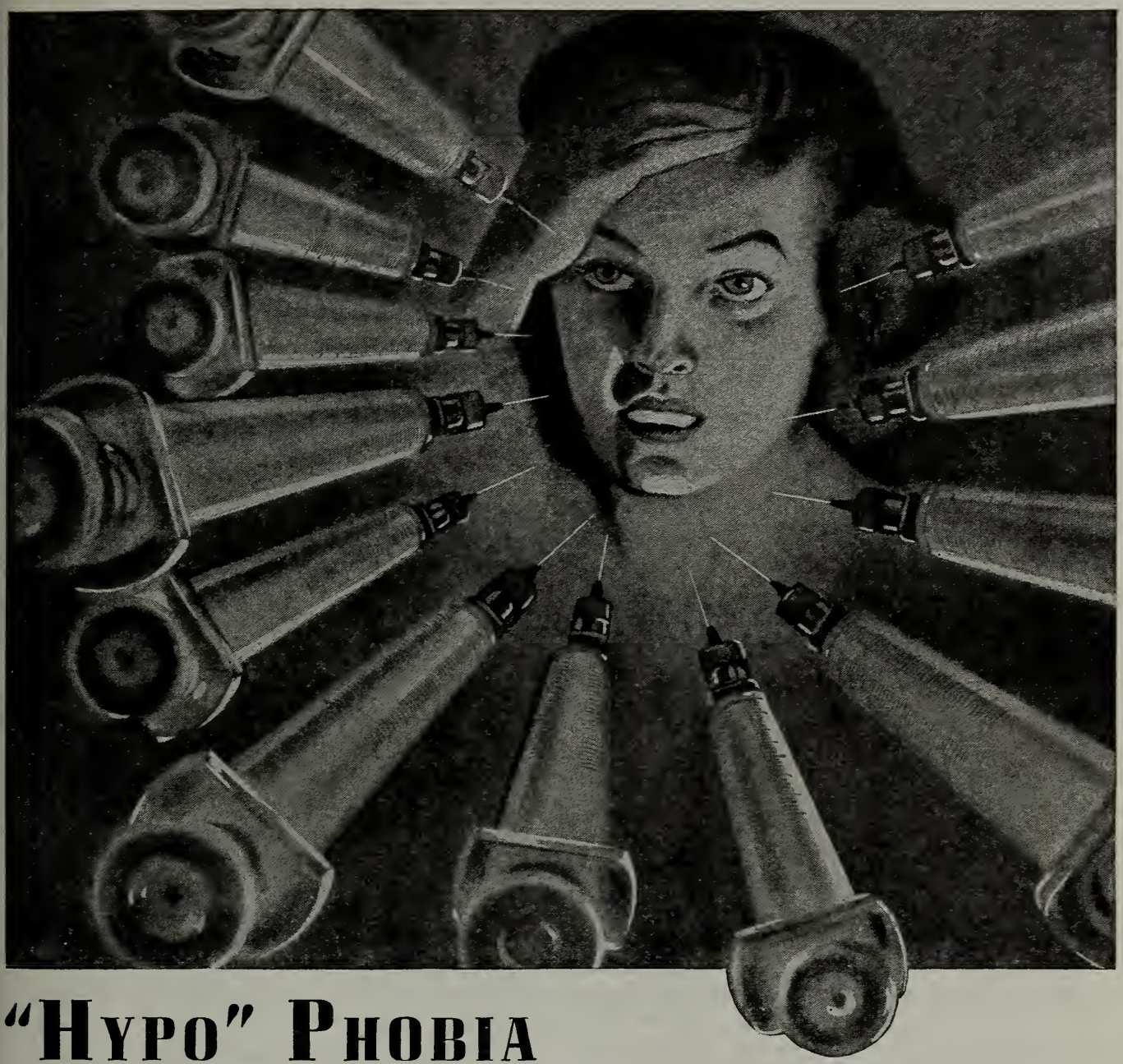
NAMES ADDED TO MILITARY ROSTER

Name	City	Rank
Alkoff, Lewis	Cincinnati	1st Lt., U.S.A.
*Anderson, Robert A.	Cincinnati	1st Lt., U.S.A.
Banfield, Harlow F.	Springfield	1st Lt., U.S.A.
*Becker, Dwight L.	Cincinnati	1st Lt., U.S.A.
*Block, Gordon L.	Cincinnati	1st Lt., U.S.A.
Boldizar, A. G.	Cleveland	1st Lt., U.S.A.
*Catron, Stuart	Cincinnatii	1st Lt., U.S.A.
*Claugus, Clarence E.	Cincinnati	1st Lt., U.S.A.
Corrill, Edgar M.	Cincinnati	1st Lt., U.S.A.
Curti, Carl P.	Cleveland	1st Lt., U.S.A.
*Dalton, Wm. J.	Cincinnati	1st Lt., U.S.A.
Davis, Ernest D.	Cincinnati	1st Lt., U.S.A.
*Devney, William	Cincinnati	1st Lt., U.S.A.
*Duby, C. J.	Youngstown	1st Lt., U.S.A.
*Elliott, Howard R.	Youngstown	1st Lt., U.S.A.
*Feehan, John Joseph	Cincinnati	1st Lt., U.S.A.
*Frame, Victor	Cincinnati	1st Lt., U.S.A.
Furtos, Norma C.	Warrensville	Passed Asst. Surg., U.S.P.H.S.
*Fuson, T. J.	Cleveland	1st Lt., U.S.A.
*Gardiner, Frederick S.	Cleveland	Lt. (j.g.), U.S.N.
*Gavin, Robert	Cincinnati	Lt. (j.g.), U.S.N.
Gibbs, Edward W.	Cincinnati	Lt. (j.g.), U.S.N.
Green, Robert S. A.	Cincinnati	1st Lt., U.S.A.
*Gruber, Adolph A.	Cincinnati	1st Lt., U.S.A.
*Gundling, Cyril	Cincinnati	1st Lt., U.S.A.
*Harbrecht, Phil J.	Columbus	1st Lt., U.S.A.
Harding, Warren G.	Columbus	Lt. Comdr., U.S.N.
*Hays, James C.	Cincinnati	1st Lt., U.S.A.
Hill, Eugene Scott	Canton	Capt., U.S.A.
Hinman, Frank, Jr.	Cincinnati	Lt. (j.g.), U.S.N.
Ittleman, William	Cincinnati	Lt. (j.g.), U.S.N.
Kahn, Joseph Wm.	Cincinnati	1st Lt., U.S.A.
Kahn, Marcel	Cleveland	1st Lt., U.S.A
Kearney, John J.	Piqua	Lt., U.S.N.
Kessler, Dale L.	Cincinnati	1st Lt., U.S.A.
*Keyes, Sydney	Youngstown	Capt., U.S.A.
*Kleinman, Roy	Cincinnati	1st Lt., U.S.A.
*Kraeft, Nelson	Cincinnati	1st Lt., U.S.A.
Krichbaum, Franklin M.	Canton	Lt., U.S.N.
*Leibovitz, Armond L.	Akron	Asst. Surg., U.S.P.H.S.
*Lerner, Samuel	Cincinnati	1st Lt., U.S.A.
Limbach, David	Cincinnati	1st Lt., U.S.A.
*Lindsey, Douglas	Cincinnati	1st Lt., U.S.A.
*MacMillan, Robert	Cincinnati	1st Lt., U.S.A.
Mamlok, Hans W.	Akron	1st Lt., U.S.A.
*Marks, Edward S.	Cincinnati	1st Lt., U.S.A.
*Miles, Howard C.	Cincinnati	1st Lt., U.S.A.
*Mitchell, Dana	Cincinnati	Lt. (j.g.), U.S.N.
*Mithoefer, James J.	Cincinnati	1st Lt., U.S.A.
*Montag, Leonard	Cincinnati	1st Lt., U.S.A.
*Moyer, Wilbur V.	Youngstown	1st Lt., U.S.A.
*Nesemann, Raymond M.	Youngstown	1st Lt., U.S.A.
Novello, A. J.	Ashtabula	Passed Asst. Surg., U.S.P.H.S.
*Nugent, Melton E.	Youngstown	1st Lt., U.S.A.
Parsons, Grant E.	Cleveland	Passed Asst. Surg., U.S.P.H.S.
Peatee, Roger A.	Weston	1st Lt., U.S.A.
Perkins, John R.	Cincinnati	1st Lt., U.S.A.
Petersilge, Carl Lorenz	Cleveland	1st Lt., U.S.A.
Pfahler, Charles J.	Cincinnati	1st Lt., U.S.A.
*Pichette, C. E.	Youngstown	1st Lt., U.S.A.
*Priest, Robert J.	Cleveland	1st Lt., U.S.A.
*Prosser, Howard E.	Youngstown	Capt., U.S.A.
*Ransohoff, Joseph II	Cincinnati	1st Lt., U.S.A.
*Rich, Joseph R.	Cincinnati	Capt., U.S.A.
*Rosenberg, Lee Sander	Cincinnati	1st Lt., U.S.A.
*Schnug, George E.	Cincinnati	1st Lt., U.S.A.
*Schwinger, Aaron	Cincinnati	1st Lt., U.S.A.
Scott, Charles, Jr.	Cincinnati	1st Lt. U.S.A.
Setnor, S. S.	Cleveland	Lt. (j.g.), U.S.N.
*Simpson, James R.	Cincinnati	Lt. (j.g.), U.S.N.
Smith, Clarence V.	Cincinnati	1st Lt., U.S.A.
*Smith, Nelson M.	Cincinnati	1st Lt., U.S.A.
Spears, George N.	Cleveland	1st Lt., U.S.A.
*Stoneburner, Wesley H.	Cleveland	1st Lt., U.S.A.
*Swan, Harold R.	Cleveland	1st Lt., U.S.A.
*Thumann, Robert C.	Cincinnati	1st Lt., U.S.A.
*Trimbur, Nevin R.	Youngstown	Lt., U.S.N.
Uthoff, Carl W.	Cleveland	Lt. (j.g.), U.S.N.
*Utrecht, Arthur	Cincinnati	1st Lt., U.S.A.
*Veit, John	Youngstown	1st Lt., U.S.A.
*Westerbeck, Daniel John	Cincinnati	1st Lt., U.S.A.
White, Charles A.	Cleveland	1st Lt., U.S.A.
Woliver, Edward	Cincinnati	1st Lt., U.S.A.
*Zwalsh, Roman John	Cleveland	1st Lt., U.S.A.

WIN PROMOTIONS

Name	City	Rank
Abrahamson, Ira A.	Cincinnati	Col., U.S.A.
Anderson, John B.	Cleveland	Comdr., U.S.N.
Banning, Wm. V.	Shreve	Capt., U.S.A.
Bayless, Francis	Cleveland	Lt. Col., U.S.A.
Beck, Claude S.	Cleveland	Col., U.S.A.
Carter, Wm. H.	Cleveland	Capt., U.S.A.
Creamer, D. M.	Bellaire	Capt., U.S.A.
Devins, Edw. J.	Cincinnati	Capt., U.S.A.
Doernberg, Robert J.	Spencerville	Capt., U.S.A.
Dorner, Arthur F.	Akron	Lt. Col., U.S.A.
Elkins, Charles W.	Cleveland	Major, U.S.A.
Extejt, Andrew J.	Toledo	Capt., U.S.A.
Falor, Wm. H.	Akron	Major, U.S.A.
Forsythe, Wm. E.	East Cleveland	Capt., U.S.A.
Gebauer, Paul W.	Cleveland	Major, U.S.A.
Glomb, Albert M.	Cleveland	Lt. Comdr., U.S.N.
Goldman, Frederick M.	Cincinnati	Lt., U.S.N.
Grigsby, Robert E.	Cincinnati	Major, U.S.A.
Hamilton, Lester A.	Athens	Capt., U.S.A.
Hansen, Paul G.	Warrensville	Lt. Col., U.S.A.
Hathorn, H. E.	Youngstown	Major, U.S.A.
Hauman, H. L.	Toledo	Major, U.S.A.
Hawkins, Benjamin L.	Cincinnati	Major, U.S.A.
Hayahsi, Shigeki	Cleveland	Capt., U.S.A.
Hazel, Woodrow S.	Youngstown	Capt., U.S.A.
Ivins, Paul N.	Hamilton	Lt. Col., U.S.A.
Kalmon, Morris	Akron	Major, U.S.A.
Kreindler, Louis	Cincinnati	Major, U.S.A.
Kronenberg, Sanford	Youngstown	Capt., U.S.A.
Kupec, J. B.	Youngstown	Capt., U.S.A.
Lauer, Howard	Dayton	Capt., U.S.A.
Lombardi, L. F.	Akron	Capt., U.S.A.
Mattocks, Theo. R.	Marietta	Capt., U.S.A.
McClintock, Robert S.	Youngstown	Passed Asst. Surg., U.S.P.H.S.
Mogg, Albert M.	Youngstown	Capt., U.S.A.
Myers, Stanley A.	Youngstown	Lt. Comdr., U.S.N.
Phillips, A. K.	Youngstown	Capt., U.S.A.
Phillips, Ralph L.	Columbus	Capt., U.S.A.
Possner, Howard E.	Youngstown	Capt., U.S.A.
Puppel, A. D.	Delaware	Major, U.S.A.
Ralston, Louis G.	Youngstown	Capt., U.S.A.
Rardin, Thomas E.	Columbus	Major, U.S.A.
Renner, John A.	Youngstown	Lt. Comdr., U.S.N.
Rohr, Lovell W.	Columbus	Major, U.S.A.
Rudolph, Jack	Columbus	Major, U.S.A.
Schellhase, F. L.	Youngstown	Capt., U.S.A.
Scott, John M.	Canton	Major, U.S.A.
Smith, F. A.	Akron	Comdr., U.S.N.
Sokol, Charles R.	Youngstown	Major, U.S.A.
Stahl, R. H.	Akron	Capt., U.S.A.
Stas, Carl A.	Cleveland	Capt., U.S.A.
Stine, Geo. Thomas	Columbus	Lt. Col., U.S.A.
Tatum, C. F.	Akron	Capt., U.S.A.
Turek, Robert O.	Cleveland Heights	Capt., U.S.A.
Ward, David P.	Pemberville	Major, U.S.A.

(Continued on page 980)



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Wells, Wm. M.	Columbus	Capt., U.S.A.
Wertheimer, Lee C.	Cincinnati	Capt., U.S.A.
Wetzel, Ralph E.	Cuyahoga Falls	Lt. Comdr., U.S.N.
Yurick, Edward A.	Cleveland	Major, U.S.A.

TABULATION BY COUNTIES

Adams	2	Guernsey	6	Muskingum	9
Allen	37	Hamilton	479	Noble	1
Ashland	12	Hancock	13	Ottawa	9
Ashtabula	18	Hardin	7	Paulding	2
Athens	11	Harrison	4	Perry	4
Auglaize	6	Henry	3	Pickaway	5
Belmont	14	Highland	8	Pike	2
Brown	4	Hocking	4	Portage	2
Butler	30	Holmes	2	Preble	7
Carroll	1	Huron	16	Putnam	6
Champaign	9	Jackson	1	Richland	38
Clark	37	Jefferson	29	Ross	24
Clermont	9	Knox	11	Sandusky	12
Clinton	8	Lake	18	Scioto	20
Columbiana	11	Lawrence	6	Seneca	12
Coshocton	4	Licking	17	Shelby	7
Crawford	9	Logan	8	Stark	100
Cuyahoga	747	Lorain	40	Summit	151
Darke	6	Lucas	161	Trumbull	27
Defiance	4	Madison	6	Tuscarawas	20
Delaware	7	Marion	16	Union	2
Erie	10	Mahoning	128	Van Wert	9
Fairfield	9	Medina	13	Vinton	2
Fayette	2	Meigs	3	Warren	4
Franklin	241	Mercer	6	Washington	8
Fulton	6	Miami	14	Wayne	14
Gallia	5	Monroe	1	Williams	8
Geauga	4	Montgomery	153	Wood	19
Greene	7	Morgan	3	Wyandot	3

Total 2973

All Ohio Physicians Invited to Hear Addresses by Outstanding Speakers at Cincinnati Academy Sessions

The Cincinnati Academy of Medicine, through its Program Committee headed by Dr. Eugene B. Ferris, has arranged for an outstanding group of speakers on currently important medical subjects for its 1944-45 scientific program. In order that the benefits of this excellent program may be obtained by as large a number of Ohio physicians as possible, the Academy has extended a general invitation to all physicians in Southern and Southwestern Ohio—in fact any Ohio physician—to attend any or all of the meetings which have been arranged.

Following is the schedule of speakers, the date of their appearances, and the subject to be discussed. Sessions will be held in the Academy auditorium, Union Central Annex Building, Cincinnati, in the evening, with the exception of the October 3 and Feb. 20 meetings, which will be held in the auditorium of the College of Medicine, Eden and Bethesda Avenues, and the Jan. 16 and 17 meetings, which will be at Children's Hospital, Elland and Bethesda Avenues.

October 3—Dr. Chester S. Keefer, professor of medicine, Boston University, School of Medicine, Boston; "Penicillin".

October 17—Dr. Lawrence Kubie, associate psychiatrist, Mt. Sinai Hospital, New York; "Psychotherapy in Medical Practice".

November 7—Dr. Herbert C. Maier, instructor in surgery, Columbia University, New York; "Surgical Treatment of Pulmonary Suppuration".

November 21—Dr. Shields Warren, assistant professor of pathology, Harvard Medical School, Boston; "The Early Diagnosis of Cancer". (Joint Meeting with the Cancer Council.)

December 5—Dr. Eugene Stead, Jr., professor of medicine, Emory University, Atlanta; "Mechanism and Treatment of Shock and Circulatory Collapse". (Joint Meeting with the Heart Council.)

December 19—Dr. Frederick C. Irving, professor of obstetrics, Harvard Medical School, Boston; "Cesarian Section".

January 2—Dr. Otto Engleke, health commissioner, Ann Arbor, Michigan; "The Relations Between the Health Department and the Doctor".

January 16 and 17—The B. K. Rachford Lectures by Dr. Alvin Coburn, Lt. Commander, (MC) USNR, assistant professor of medicine, Columbia University, New York; "Therapy and Prevention of Rheumatic Fever".

February 6—Dr. Merrill C. Sosman, clinical professor of roentgenology, Harvard Medical School, Boston; "X-ray Diagnosis".

February 20—The Roger Morris Lecture by Dr. George Heuer, professor of surgery, Cornell University, New York.

March 6—Dr. R. H. Williams, assistant professor of medicine, Harvard Medical School, Boston; "Thiouracil in the Treatment of Hyperthyroidism".

March 10—Program to be arranged by the Nutrition Council.

April 3—Dr. Katherine Dodd, associate professor of pediatrics, University of Cincinnati, College of Medicine; "Cystic Fibrosis of the Pancreas".

April 17—Dr. Edwin P. Lehman, professor of surgery, University of Virginia, Department of Medicine, Charlottesville; "Diagnosis and Treatment of Intestinal Obstruction".

May 1—Dr. Ovid O. Meyer, associate professor of medicine, University of Wisconsin Medical School, Madison; "The Therapeutic Use of Anticoagulants Including Heparin and Dicoumarol".

May 15—Lt. Col. Roy Grinker, M.C., A.A.F. Director of Professional Services and Psychiatry; "The Medical, Psychiatric and Social Problems of War Neuroses".

Circleville—Health commissioner of Pickaway County for seven years, Dr. A. D. Blackburn was recently appointed for two more years.



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WAR NOTES

Maj. Gen. Paul R. Hawley, chief Army medical officer in the European Theater of Operations, was awarded the honorary doctorate of laws, by his Alma Mater, University of Cincinnati, in an unprecedented radio exchange, on the evening of August 25, as a feature of the 125th commencement of the University of Cincinnati College of Medicine. Excerpts from Gen. Hawley's radio acknowledgment of the honor follows:

"A degree is not negotiable, but there are no such limitations placed upon the honor attached to the degree. This honor is mine to dispose of as I see fit.

"I am but one member of a great team dedicated to saving the lives of American soldiers and to preventing their suffering. This is a good team, a team of which I am intensely proud and of which you, too, can be proud.

"No matter how grave the wound, no matter how serious the condition, whenever one faint spark of life has remained, this team has restored to health 97 out of every 100 wounded.

"So I hereby convey to my teammates, to each officer, nurse and enlisted man of the Medical Service of the E. T. O., his or her fair share of this honor. Among those deserving the larger shares, I would place those brave and devoted medical soldiers who accompany their infantry comrades into action, who share with them all the dangers of combat.

"They are the unsung heroes of this war.

"The general hospitals in the European theater are as fine as any in the world. In this distinguished company, the general hospital from the University of Cincinnati is outstanding. For early service in France, I selected those general hospitals that had made the best record in England, and that one was among the first to move to France. Let no one think that in this selection I was influenced by loyalty to, or affection for, my own university.

"On the contrary, I am more critical of this hospital than of any other of my hospitals. It must be superior. I am very pleased and very proud that it has met my demands."

Gen. Hawley concluded by paying tribute to his professional consultants, among whom is Col. Derrick T. Vail, Cincinnati, senior consultant in opthalmology for the European Theater of Operations.

In presenting Gen. Hawley for the degree in absentia, Dr. Stanley Dorst, Dean of the College of Medicine, lauded him as a "physician, scholar, administrator, and soldier, twice decorated for conspicuous military achievement". The diploma and hood, symbolic of the degree were handed to Mrs. Bina C. Hawley, College Corner, mother of Gen. Hawley.

The Oak Leaf Cluster to the Silver Star has been awarded Maj. Jay P. Roller, Luckey, for "outstanding devotion to duty" in administering medical aid to eight wounded soldiers under heavy fire while in Sicily. Despite the loss of several of his own medical personnel, Maj. Roller continued to render aid throughout the night. His citation states that on this occasion and countless others, he demonstrated such gallantry and disregard for self in the performance of hazardous missions that his courage and devotion to duty are a constant inspiration to the officers and men of his regiment.

* * *

Serving with the Japanese-American combat group in Italy, Capt. Shigeki Hayahsi, Cleveland, was wounded on July 17. He has been in the service for 15 months, and went overseas in April. Capt. Hayahsi is a graduate of the University of Hawaii and Western Reserve University School of Medicine.

* * *

After 22 months overseas, the last two months of which were at Anzio, Italy, Capt. David L. Hirst, Miamisburg, is now in the staff of the Station Hospital, Erie Proving Grounds, Lacarne, near Camp Perry.

* * *

Capt. D. M. Creamer, Bellaire, was recently transferred from Hawaii to Guam.

* * *

According to an AP story from Fort Devens, Mass., Lt. Col. George T. Stine, aged 29, Columbus, recently named executive officer of the Lovell General Hospital convalescent facilities, is the youngest Fort Devens officer of his rank and one of the youngest lieutenant-colonels in the Army Medical Corps. He graduated at Ohio State University College of Medicine in 1939.

* * *

Bits of news about Cleveland medical officers . . . Capt. Joe Heimann, returned to Newport News, Va., from another round trip on hospital ships. This time visited Rome, and had an audience with the Pope . . . Major J. W. Ockington, back in Africa at a rest camp after duty with a general hospital unit in Italy . . . Capt. Henry H. Roenigk flew to India in a B-29. As flight surgeon, has flown over the hump several times to China . . . Lt. John H. Tildes, with a fleet hospital, gained 11 pounds while in a 16-day leave in Sidney, Australia . . . C. O. of a Station Hospital in Morocco is the assignment of Lt. Col.



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G. A. Tischler . . . Lt. Col. Roger Egeberg, personal physician to General MacArthur, home on a 30-day leave . . . Major Paul Gebauer, with the Lakeside Unit (Fourth General Hospital, now in New Guinea) home on leave due to his wife's illness . . . Lt. Col. Donald M. Glover, chief of surgery with the Fourth General, returned to his post after a brief visit home . . . Capt. Joseph Miceli denies rumor that he was sick or missing. He is with an Eng. Bn. in the Pacific tropics . . . Maj. John H. Lazzari, 30 months in the South Pacific, originally with the Lakeside Unit, now on a hospital ship which commutes between Australia and the islands. Says the tropics are a kaleidoscopic mess of ants, bugs, flies, mosquitoes, lizards, too much sun, too much rain . . . Lt. Col. Francis Bayless had been in England with a general hospital, returned to Crile General Hospital as a patient in March, now fine and on duty at DeWitt General Hospital in California, as pathologist . . . Maj. A. A. Pimsner, chief of surgery with a station hospital in New Guinea, was right busy during the Buna campaign. Has lived in a tent for two years and says many of the doctors have little gardens, raise tomatoes and cucumbers to relieve the monotony of canned food . . . Lt. Col. P. F. Briola, on the staff of the Reconditioning Program at the Station Hospital, Camp Roberts, Calif. . . . Wears the Legion of Merit for meritorious service in New Georgia . . . Capt. Webb P. Chamberlain, with the Fourth General, recently wrote home for garden seed . . . Capt. D. C. Darrah, doing surgery at the Regional Hospital, AAF, Roswell, New Mexico . . . Home from the South Pacific, Maj. C. W. Elkins is at O'Reilly General Hospital, Springfield . . . Lt. Comdr. Albert Glomb, on shore duty in Cleveland, recently a patient at Crile General, fully recovered and expecting a transfer.

* * *

Twice-decorated Major Louis Kreindler, Cincinnati, is with the 25th Inf. Div. in the South Pacific. He was awarded the Legion of Merit for exceptionally meritorious service during a battle on Guadalcanal, and the Silver Star for courageous service during the fighting on New Georgia Island.

* * *

Col. Claude S. Beck, Cleveland, surgical consultant for the Fifth Service Command, with headquarters at Ft. Hayes, Columbus, is the new president of the American Association for Thoracic Surgery.

* * *

The Bruns General Hospital, Santa Fe, N. M., under the command of Brig. Gen. Larry B. McAfee, has been designated as an Army center for the treatment of tuberculosis. The hospital is staffed with tuberculosis experts, and utilizes the most modern equipment and methods of treatment.

While Capt. Ray M. Turner, Springfield, is on duty at the Columbus, Miss., Air Base, his wife, Dr. Lillian M. Posch, is college physician and director of the hospital infirmary at the Mississippi State College for Women.

* * *

Major Benjamin L. Hawkins, Cincinnati, now on duty at the Station Hospital, Camp Bowie, Texas, after two years in the ETO, was married to Miss Ruth Benzon at Dawson, Minn., August 17. Miss Benzon was Red Cross recreational director at Camp Bowie.

* * *

Dr. Charles J. McDevitt, Cincinnati, has returned to private practice after nearly two years with the United States Public Health Service as a Senior Surgeon. While overseas, Dr. McDevitt visited his eldest son, Lt. Charles J. McDevitt, Jr., with the Army Air Forces in England. His second son, Sgt. William H. McDevitt, is in the Southwest Pacific, with the Army's chemical warfare service.

* * *

Capt. Norman Friedman, Cleveland, is a regimental surgeon in the 37th Division—somewhere in the Southwest Pacific.

* * *

Now stationed at the Bureau of Medicine and Surgery in the Navy Department, Washington, D. C., working on the photofluorographic Chest Survey program, Lt. Joseph C. Placak, Jr., writes a note of appreciation to the officers of the State Association for continuing him on *The Journal's* mailing list. He states that during the last two years while he was stationed in the South Pacific, the regular arrival of *The Journal* was most welcome.

* * *

Capt. J. M. Gettrost, Columbus, was home recently on a 21-day leave after a year in New Guinea. He was scheduled to report to Crile General Hospital, Cleveland.

* * *

You medical officers who have sat on a Court Martial should get a kick out of "Maudlin Thoughts While Sitting on Courts Martial", written by Major Ivor MacIvor Campbell, Akron, from somewhere in the ETO. Major Campbell was in England as a flight lieutenant with the RCAF, and shortly after the United States entered the war, transferred to the AAF. Here's his description (with a couple of deletions) of a Court Martial:

"There must have been a continuous accelerated regression in the dispensation of military justice, probably since its inception. The proceedings are marked by a repetition of needless questions of an almost completely inane character. The points of evidence are as repetitious as water dropping from a faucet, and are hammered home with all the delicacy of a bull elephant in rut . . . At its worst, in the more technical cases, it is



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a wearisome ordeal, very flattening to the posterior muscles, benumbing to the intellect, encouraging to doodling, and eventually becomes exasperating in the extreme, as time drags wearily on. The sun shines through the windows, the words run on and on, in a marked diarrhoea of loosely connected ideas. The accused is at first alert, later frightened by what seems to be a ponderous machine in inexorable progression; eventually he becomes wearied and somnolent, and towards the end mercifully becomes partially narcotized, only rallying slightly to hear the result of the deliberations of the august and wearied body before which he has suffered . . . The announced result, regardless of its severity or otherwise comes always as a relief. Legal forms and fancies have triumphed, every————connected with the whole sorry spectacle is relieved, with the exception of the shysters, who have had their appetites whetted for more of the rites, sacrificial or otherwise . . . The court adjourns, the bar is open, night falls eventually and Morpheus flutters his (or is it her) wings over the tired participants, and all is again serene."

* * *

The Bronze Star Medal was recently awarded to Capt. Andrew J. Extejt, Toledo. He was decorated for military operations against the enemy in Normandy, June 7-10. Capt. Extejt has been overseas for more than a year, and also saw action in Africa, Sicily and Italy.

* * *

Out in the Central Pacific, on Tinian in the Mariana Islands, is the location of Lt. Comdr. A. C. Renz, Cincinnati, on the staff of a Naval Medical Hospital Facility.

* * *

Comdr. E. R. Hammersley, Tuscarawas; Lt. Comdr. P. E. Kellogg, Ashland, and Lt. R. V. Schneider, Toledo, now on sea duty, send FPO addresses so that they won't miss any issues of *The Journal.* Sorry, but censorship regulations forbid publishing names of ships.

* * *

Lt. Col. Richard L. Meiling, Columbus, formerly executive officer of the Operations Division of the Air Surgeon's Office, has been designated Special Assistant to the Air Surgeon, a position recently created under a partial reorganization of the Air Surgeon's Office. Col. Meiling will continue to be located in Washington. His duties include coordination with civilian and military medical agencies on postwar medical problems, including demobilization. He also serves as medical liaison officer with Headquarters of the 20th Air Force, as liaison officer with the Plans Division of the Air Staff, and liaison officer for the Air Surgeon on all special projects, Headquarters, Army Air Forces.

* * *

Home in Columbus after 17 months with a station hospital in India, Lt. C. C. Landen reported at Fletcher General Hospital, Cambridge, after a 21-day leave.

* * *

Capt. F. L. Schellhase, Youngstown, has been in New Guinea for over a year, where he was squadron surgeon for the Fifth Air Force Advanced Echelon. His latest assignment is to travel about the forward areas among Fifth A.F. units organizing lectures and training programs in the treatment of gas casualties, for the benefit of the unit surgeons. Capt. Schellhase reports having had a breather of five weeks in the Australian mainland, including two weeks' temporary duty in Brisbane, 15 days' leave in Sidney and Melbourne, and a one-day unexpected stop in Canberra, the nation's capital, where he was forced down by icing winds. He enjoyed the leave except for Australian weather which is too cold for blood like his, thinned out by almost a year in the tropics. Branching out into the field of veterinary medicine, Capt. Schellhase has been taking care of dog mascots, "which don't do well in this climate either".

* * *

An announcement by the Navy Department credits a Cleveland physician, Lt. Comdr. Russell G. Witwer, together with another Navy doctor, with designing a flying suit with "built-in tourniquets" to aid in the control of bleeding among wounded pilots during combat. The suit as designed, has four adjustable tourniquets, one in each arm and leg.

* * *

Ohio medical officers who stop off in the Philippines on the road to Tokyo, should be on the lookout for two unfortunate Ohio colleagues who are held as prisoners of war at Japanese Prison Camp No. 2, Davao, capital of Mindanao Island. They are: Capt. Walter F. Bartz and Capt. Nathan D. Belinky, both from Youngstown. They were at Corregidor when it fell to the Japs in 1942.

* * *

Capt. Richard Hotz, Toledo, was wounded in action in Saipan, Aug. 6, according to press dispatches. The injuries resulted from a shell explosion while he was operating in an advanced base hospital.

* * *

Recent new addresses within the United States: Major W. A. Davin, Hamilton, Fort Devens, Ayer, Mass.; Major W. G. Drown, Warren, AAF, Ardmore, Okla.; Major A. O. DeWeese, Kent, Ellington Field Hosp., Houston, Texas; Capt. Robert J. Doernberg, Spencerville, Station Hosp., AAF, Lincoln, Nebr.; Lt. Col. James H. Carson, Martins Ferry, Crile General Hosp., Cleveland; Lt. Comdr. Geo. Crile, Jr., Cleveland, U. S. Naval Hosp., San Diego; Lt. Comdr. W. C. Clark, Dayton, U. S. Naval Hosp., Corpus Christi, Texas; Lt. S. L. Burkhardt, Steubenville, Anti-Aircraft Training Center, Price's Neck, Newport, R. I.; Capt. Alton W. Behm, Chardon, Moore Gen. Hosp.,

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* * *

Capt. Wm. F. Mitchell, Columbus, with a B-29 group in India, writes home: "The Himalayas are beautiful and awe-inspiring, but can't compare with Verne Dodd's stamping grounds near Jackson's Hole, Wyoming. It is funny how we had to travel half way around the world only to find that Shangri La covers an eight-mile radius from Broad and High."

* * *

Capt. Edward G. Klopfer, Columbus, home after over two years in the South Pacific with the 37th Division, is now at Camp Buckner, N. C.

* * *

Lt. Comdr. C. F. Bellamy, Cincinnati, recently completed a course in chemical warfare at Edgewood, Md., and is now on duty at the Yard Dispensary, U. S. Naval Drydocks, Hunter Point, San Francisco, Calif.

* * *

Recently moved from Ft. Jackson, S. C., to the 1319th Engineer Regt., Camp Sutton, N. C., Major O. D. Ball, New Lexington, writes that his duties are purely administrative as a regimental surgeon, with emphasis on preventive medicine. Thanks, Major, for heeding our request in the August issue for news for the War Notes section.

* * *

Capt. Carl A. Stas, Cleveland is roentgenologist with an evacuation hospital unit, "not in a combat area", but with a San Francisco APO. The unit is made up of physicians either directly on the staff or affiliated with the New York Postgraduate Hospital. Recently on detached service with a station hospital, Dr. Stas has been sharing the responsibility of the roentgenological department with a medical officer from Buffalo, N. Y. He has this to say about his duties: "The work here in the department is quite varied and plentiful. We usually work from 8:00 A. M. to 4:30 P. M. as a regular routine and then there is the emergency work which comes in every day and quite frequently. So that there can't be any complaint of the lack of material which is mainly divided into traumatic and purely diagnostic categories. One gets to interpret quite a number of films and the

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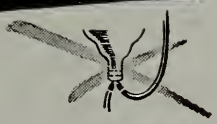




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work runs up into the thousands. Added to the X-ray work each Monday a clinical ward round discussion is made and thereat various diagnostic phases are discussed. That way the X-ray department not only sees the interesting films but has a chance to really study all the clinical and laboratory phases and derive a composite picture of an intriguing diagnostic problem."

* * *

The hobby of Major Dan J. Whitacre, Columbus, is magic and sleight of hand tricks. He puts it to good use aboard an Army transport to which he is attached in the South Pacific. According to a news story, twice a day, every out-bound and in-bound trip, until every soldier aboard has attended, the major puts on a one-man, one-hour magic show. While at Ohio State, Dr. Whitacre was on the wrestling team for four years and in his last two years was Big Ten heavyweight champion.

* * *

Now at the M. D. R. P., Billings General Hosp., Ft. Benjamin Harrison, Ind., Major M. C. Archer, Medina, writes that during three years overseas in the Hawaiian area he enjoyed reading the articles in *The Journal*, "especially the articles giving all the news and whereabouts of the Ohio doctors all over the world". Dr. Archer was chief of the X-ray service at Tripler General Hospital.

* * *

Capt. Orin R. Yost, Akron, is an instructor in The School of Military Neuropsychiatry, Mason General Hospital, Brentwood, N. Y.

* * *

A more abundant supply of medicines for civilians was forecast in a news dispatch from Washington, dated August 21, which stated that the Navy has disclosed that its own stocks have reached a level sufficient to permit it to stop purchases for six months.

* * *

The Legion of Merit was presented to Col. Edgar C. Jones, M. C., U. S. A., (ret.), McConnelsville, at a formal retreat ceremony recently at Ft. Hayes, Columbus. The award was made by Maj. Gen. James L. Collins, commanding general of the Fifth Service Command. The citation reads as follows:

"For service as Assistant Surgeon, Fifth Corps Area; Surgeon, Fifth Corps Area; and later as Chief of the Medical Branch, and Surgeon, Fifth Service Command, during a period of expansion and reorganization from October 22, 1940, to June 30, 1944. In the performance of his duties he displayed in the highest degree the qualities of intelligence, loyalty, devotion to duty, sound judgment and a thorough understanding of this mission. His contribution to the war effort has been a most effective one, rendered always with a most unselfish devotion to the Nation's welfare."

The first hospital for German prisoners-of-war staffed by German doctors, Glennan General Hospital, has been opened at Okmulgee, Okla. Opening of the hospital inaugurates the new policy of the Army Medical Department of establishing separate prisoner-of-war hospitals staffed with doctors and medical corpsmen of the prisoner's own nationality. It is anticipated that another similar hospital will be opened shortly.

* * *

Lt. Col. Joseph M. Hayman, Cleveland, recently returned from more than two years with the Lakeside General Hospital unit in the South Pacific, is in command of the medical center at Moore General Hospital, Swannanoa, S. C., designated for the study and treatment of tropical diseases.

* * *

Medical officer at the Naval Recruiting Station in Columbus is the new assignment of Lt. Comdr. Thos. W. Geoghegan, Fostoria. He had been at Great Lakes, Ill., since April, when he returned after 14 months in the South Pacific. Readers of War Notes will recall that Dr. Geoghegan was chief medical officer of the U. S. S. McCawley, which was sunk off the Solomon Islands in July, 1943.

* * *

A Dayton newspaper recently published a picture of Lt. F. Blair Webster, Bellefontaine, with other Marines, atop a pile of equipment in Guam. Information with the picture stated that Dr. Webster is one of the American medicos who withstood the first Banzai attack by the Japs, July 25 and 26, which almost overran the hospital and patients.

* * *

Col. Howard C. Eddy, Cleveland, is with the Sixth Armored Divison, one of the outfits which taught the Germans a thing-or-two about blitzkriegs in Northern France.

* * *

From the deluge of new A. P. O.'s received at the State Headquarters Office recently, Ohio medical officers around the globe should be on the lookout for their erstwhile Buckeye colleagues. Then, how's for sending the War Notes editor a "Fancy meeting you here" item!

* * *

Occasionally *The Ohio State Medical Journal* is recognized by receiving a press release directly from an Army public relations office. (All such contributions are gratefully received.) Here, in part, is one from away out in the Pacific:

"A 7TH AAF BOMBER BASE IN THE MARIANAS:—One of the most unusual fees of his medical career—a highly prized 50 yen Jap bill—was given to Maj. Robert C. Haubrich, Columbus (Ohio), 7th AAF Bomber Command surgeon,

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by his first Marianas patient, a grateful Marine. "'Doc', said the Marine when the 7th AAF surgeon had completed his dressing, 'I've got two of these 50-yen bills and I want you to have one of them. They're pretty scarce, but I wouldn't advise you to cash it because I'm afraid the Bank of Japan is headed for rough times.'

"Maj. Haubrich, whose home is at 1745 King Ave., Columbus, and who also practiced in Pataskala, landed in the Marianas with an advance party soon after D-Day. They were to pick a site to house the air and ground personnel of the command when it moved forward from the Marshalls.

"A Jap sugar cane field was chosen. Maj. Haubrich's first problem was to cut and burn the rotting cane in an attempt to drive out the swarms of flies and mosquitoes, and to level the deep furrows characteristic of cane fields. He supervised the raising of tents, location and construction of mess halls, observed sanitary conditions and found safe drinking water for the men.

"'Neither the lack of materials with which to work, nor the constant rain and humidity were as bothersome as the flies and mosquitoes', he said. 'They carry all sorts of diseases, so we went after them at once with every chemical we had. In fact, we even tried a few of our own concoctions. To date we've had no illness attributed to insects.'

"Maj. Haubrich attended Ohio State University where he played football, and was an All-American tackle in 1932. He received his medical degree in 1937. In May, 1942, he was called to active duty with the AAF, and received his flight surgeon's wings at Randolph Field. He joined the 7th AAF in June, 1943."

By the way, Major, you might tell the PRO officer out there in the Marianas that some censor worked out on the release with his scissors. It may have been done by the Army Press Censor whose OK appears on the copy. Then again (and we hope we're not starting a row) maybe the culprit was the Navy censor whose stamp also was on the release. Anyway, not much harm was done. It's still a good yarn.

* * *

From New Guinea, Major C. E. McKinley, Camden, executive officer in the Medical Battalion of an Infantry Division, writes that he will be more than glad when it is possible to return and renew associations with the Preble County and State Medical societies. 'Twill be a pleasure, doctor!

* * *

Capt. L. A. Hamilton, Athens, V-mail's some kind words for *The Journal* from the island of Corsica, with the promise that his next letter will be from "Unter Der Linden". He has this to say about his meanderings:

"I have only met up with a handful of Ohio docs since leaving the States. Recently I met A. A. Hall from Columbus (Lt. Col. with a station hospital), and an orthopod from Youngstown by the name of McElroy (also a Lt. Col. with a station hospital). That was back in Italy at———. But it is not surprising that I have not met more in 19 months overseas, because I have been most of the time at the most advanced air fields, the kind of fields that are made overnight. We went all thru Africa that way, then into the Gela invasion in Sicily, and later the Salerno invasion in Italy. Spent a pleasant winter in Naples, then was in the race chasing the 'Tedeschi' up thru Rome and points north. Did manage to stop long enough in Rome to sightsee in my ambulance for a few hours. Now I am enjoying the lull before the storm here on Corsica. We have a beautiful camp along a trout stream, but the damn fish are either too dumb or too smart to grab what bait we offer" . . .

* * *

Capt. Winship H. Brown, Bowling Green, has been cited by Lieut. Gen. Mark W. Clark for outstanding performance of duty on the Anzio beachhead, Italy, from Jan. 23 to 29. Born in Nanking, China, Dr. Brown was head of the student health service at Bowling Green State University when he entered Army service. Besides Anzio, he took part in beachhead landings at Gela, Sicily; Salerno, Italy, and St. Tropez, Southern France, according to press reports. His citations, signed by General Clark, commended him for "conspicuous coolness under bombing, shell fire and falling flak, by continuing to perform his duties of administering treatment to the wounded".

* * *

Major Joseph L. Fetterman, Cleveland, executive officer of the School of Military Neuropsychiatry, which he helped to start at Lawson General Hospital, Atlanta, Ga., and which is now situated at Mason General Hospital, Brentwood, Long Island, N. Y., has been retired from duty and placed on an inactive status. He will return to Cleveland.

* * *

Brig. Gen. Frank T. Hines announced September 12 that approximately 10,000 veterans have already applied to the Veterans' Administration for the educational benefits of the G.I. Bill of Rights, with 5,600 ruled eligible and 422 at present attending colleges.

* * *

Secretary of State Edward Hummel reported Sept. 11 that 169,680 applications had been received for absent voter ballots for the November 7 election. Application letters written by members of the armed forces direct to county election boards numbered 3,357; relatives submitted 50,498 and 115,825 were government cards sent by military personnel to the secretary of state. Applications by counties included: Cuyahoga, 37,271; Franklin, 11,207; Hamilton, 19,376; Mahoning, 7,664; Summit, 7,474; Montgomery, 5,663; Lucas, 8,603 and Stark 3,526.

* * *

More new addresses in the United States: Lt. R. N. Whitehead, Bowling Green, U. S. Naval



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Hospital, Mare Island, Calif., (back from Pacific fleet duty); Lt. L. S. Pugh, Perrysburg, 116th Evac. Hosp., Ft. Jackson, S. C.; Major Robert Perlman, Cincinnati, Rhoads Gen. Hosp., Utica, N. Y.; Capt. H. H. McConkey, Canton, Riverside, Calif.; Capt. Henry A. Long, Hamilton, Reg. Hosp., Camp Swift, Tex.; Capt. Joseph H. Holmes, Fremont, Sta. Hosp., Buckingham AAF, Ft. Myers, Fla.; Capt. Robert H. Hoecker, Mt. Vernon, Nashville, Tenn.; Lt. Comdr. Joyce I. Hartman, Dayton, U. S. Navy Recruiting Station, Fresno, Calif.; Lt. (j.g.) Robert M. Inglis, Columbus, Receiving Ship Dispensary, Yerba Buean Island, San Francisco, Calif.; Lt. Daniel T. Feiman, Canton, Sta. Disp., USMC Air Station, El Centro, Calif.; Maj. Morris B. Guthrie, Columbus, CAAB, Columbia, S. C.; Lt. Charles Froug, Dayton, Camp Ellis, Ill.; Capt. Wm. H. Carter, Ravenna, AAB, Alamogordo, New Mexico; Lt. Reynold W. Wade, Jr., Toledo, Medical Advisor and Examiner SAC, Indiantown Gap Military Reservation, Indiantown, Pa.; Capt. A. B. Yasinow, Cleveland, Sta. Hosp., Camp Bowie, Tex.

* * *

Drs. H. W. Kendell and R. M. Craig, Dayton, and Dr. George X. Schwemlein, Cincinnati, reserve officers in the U. S. Public Health Service stationed at the Chicago Intensive Treatment Center, spoke on "Physiologic Studies and Technics Employed During Fever-chemotherapy of Early Syphilis" at the Twenty-third Annual Convention of the American Congress of Physical Therapy, September 6, at the Hotel Statler, Cleveland.

* * *

Lt. Col. Claude S. Perry, Columbus, chief of the EENT section in a general hospital unit now in France, was on detached service doing plastic surgery for several weeks before leaving England.

* * *

Major A. M. Weil, Akron, chief of the surgical service on a hospital ship, had an active part in the invasion of Southern France. He writes: "Our hospital ship functioned as an evacuation hospital, receiving casualties directly from the beachhead. Our staff kept nine operating tables busy constantly for 72 hours. It was a memorable experience. Major H. W. Beck, Canton, was chief anesthetist and Capt. Wm. Banning, Shreve, also was an anesthetist."

* * *

An increase in quotas for admission to officer candidate courses leading to commissions in the Medical Administrative Corps of the Army was announced by the War Department July 12. The new quotas permit acceptance of 2,000 men within the next eight weeks for 17-week courses. The increase will permit more Medical Administrative Corps officers to free members of the Medical Corps for professional duties.

Do You Know - - -

According to the U. S. Children's Bureau, the infant mortality rate in the United States for 1943 was the lowest on record—39.9 infant deaths per 1,000 live births.

* * *

Willard C. Shepard, Chicago, one of the foremost contemporary American medical artists, has been appointed art editor of W. B. Saunders Company, Philadelphia and London, publishers to the medical, dental, nursing and allied professions.

* * *

"Breakfast at Sardi's", a well-known radio program, honored Dr. Mildred L. Snyder, Middletown, recently. Shortly after being lauded as the good neighbor of the day, Dr. Snyder received an orchid by air express from Hollywood.

* * *

Through September 20, cases of infantile paralysis reported to the State Department of Health numbered 769, with 36 deaths. Comparable figures for the same period in 1943 were 111 cases and 12 deaths. Total cases reported during 1943 were 184, with 12 deaths.

* * *

Dr. C. C. Sherburne, Columbus, Immediate Past-President of the Ohio State Medical Association, has been appointed by Governor John W. Bricker to the Governor's Committee for services to service men and veterans, their dependents and survivors.

* * *

A national conference on postwar venereal disease control will be held in St. Louis, Nov. 9-11, under the auspices of the United States Public Health Service. Surgeon General Thomas Parran will preside. State and local health officers, venereal disease control officers, practicing physicians and others engaged in VD control activities are invited to attend.

* * *

Dr. John Romano, professor of psychiatry at the University of Cincinnati College of Medicine, conducted a graduate teaching program Sept. 6-25 at Dallas, Texas, for Army medical officers on duty in hospitals of the Eighth Service Command. The teaching program was sponsored by the Rockefeller Foundation for Medical Research. Dr. Romano has been appointed visiting psychiatric consultant to the Command.

* * *

In the last 11 years, the American people have contributed $29,562,742.54 in the fight to conquer infantile paralysis, Basil O'Connor, President of the National Foundation for Infantile Paralysis, announced recently. This money was raised through the celebration of President Roosevelt's birthday and the March of Dimes, held in January of each year.

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In Memoriam

Ward Denver Coffman, M.D., Zanesville; University of Cincinnati College of Medicine, 1919; aged 53; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; died September 7. A practicing physician in Zanesville for 21 years, Dr. Coffman was very active professionally as well as in civic affairs. He was a member and former chairman of the Ohio Public Health Council; a former president of the Muskingum County Academy of Medicine, president of the Zanesville Board of Education, and member of the staff of both Good Samaritan and Bethesda hospitals. Dr. Coffman was a veteran of World War I, and a member of the American Legion. He was a member of Nu Sigma Nu and the Elks. Surviving are his widow, a son—in his third year at the University of Cincinnati College of Medicine, a sister and two brothers.

Claude Vernet Davis, M.D., Pennsville; Ohio State University College of Medicine, 1917; aged 57; member of the Ohio State Medical Association and Fellow of the American Medical Association; died August 16. An active general practitioner in Pennsville and Morgan County for 25 years, Dr. Davis was President of the State Medical Board, of which he had been a member since March 18, 1940. He was president of the Morgan County Medical Society and a member of the staff of the Marietta Memorial Hospital. During World War I, Dr. Davis served nearly a year in a base hospital in France as a first lieutenant in the Army Medical Corps. Always active in community affairs, he was a member of the Methodist Church, American Legion, I. O. O. F., Masonic Order and the Rotary Club. Surviving are his widow, two sons and three sisters.

Cyril Ostello Dozer, M.D., Roseville; Eclectic Medical College, Cincinnati, 1919; aged 50; member of the Ohio State Medical Association and the American Medical Association; died August 21. Dr. Dozer had been in Roseville for 24 years, and had a wide practice in Perry and Muskingum counties. A veteran of World War I, he was a member of the Church of Christ, American Legion, and the Masonic Order. Dr. Dozer was a member of the staff of Bethesda Hospital, Zanesville, and vice-president of the Roseville Board of Education. He is survived by his widow, his mother, a daughter and a son.

Clare Edwin Fraunfelter, M.D., Canton; Rush Medical College, Chicago, Ill., 1904; aged 67; member of the Ohio State Medical Association and Fellow of the American Medical Association; died September 4. Dr. Fraunfelter practiced in Canton for 40 years. He was a former president of the Stark County Medical Society, and a member and former president of the staff of Aultman Hospital, Canton. Dr. Fraunfelter was a member of the Lutheran Church and the Masonic Order. His widow and two sons survive.

James Caleb Gruber, M.D., Lisbon; Illinois Medical College, 1905; aged 72; member of the Ohio State Medical Association and Fellow of the American Medical Association; died September 8. A member of the staff of Salem City Hospital, Dr. Gruber practiced in Lisbon for 38 years. He was a member of the Catholic Church. Surviving are his widow, two daughters, a son, a sister and three brothers.

Joseph Leo McEvitt, M.D., Akron; Yale University School of Medicine, New Haven, Conn., 1914; aged 55; member of the Ohio State Medical Association and Fellow of the American Medical Association. Chief of staff of St. Thomas Hospital, Akron, Dr. McEvitt practiced there for 25 years. As a first lieutenant in the Army Medical Corps during World War I, he went overseas with the Bellevue Hospital unit.

Robert Ramroth, M.D., Marion; Western Reserve University School of Medicine, 1895; aged 72; member of the Ohio State Medical Association and the American Medical Association; died September 2. Dr. Ramroth practiced in Marion for 49 years. He was a member of the Catholic Church and for many years was organist and director of the choir of the local church. Dr. Ramroth also was a violinist, and had played in civic orchestras. He was a charter member of the local Knights of Columbus council and a charter member of the local Eagles Lodge. His widow and two daughters survive.

Edgar Shane Newlin, M.D., North Adams, Mich.; Miami Medical College, Cincinnati, 1891; aged 76; died September 5. Dr. Newlin practiced in Dayton for 15 years, also in Indiana and Kentucky. He retired a year ago. His widow and a daughter survive.

In an address at the recent session of the American Congress of Physical Therapy in Cleveland, Capt. Charles F. Behrens, M.C., U.S.N., chief of the Navy's radiological service, quoted figures of the Federal Security Agency, asserting that 23,000,000 Americans had substantial physical handicaps and 2,000,000 of these need rehabilitation.



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Activities of County Societies

First District

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CLINTON

"Hospital Care Plans", was the topic discussed by Mr. W. C. Sprigg at a meeting of the Clinton County Medical Society, September 7, at the General Denver Hotel, Wilmington. — R. W. DeCrow, M.D., secretary.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

MIAMI

Lt. Col. E. Neth Schillinger, M.C., of the Veterans' Administration Facility, Dayton, spoke on "Medical Problems of the Returning Soldier from World War II", at a meeting of the Miami County Medical Society, Sept. 1, at Memorial Hospital, Piqua. A sound-movie, in technicolor, "Modern Nutrition", was shown through the courtesy of E. R. Squibb and Sons.—George A. Woodhouse, M.D., secretary.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

PUTNAM

The Putnam County Medical Society resumed its meetings after the summer recess with the annual meeting at Pandora, with wives of the members present. The meeting was held in Pandora Park, under the trees on the river bank, with Dr. Harry A. Neiswander in charge of arrangements. Following a sumptuous dinner, an address was given by Dr. H. H. Brueckner of the Lima District Tuberculosis Hospital. The paper was interesting and informative.—J. R. Echelbarger, M.D., corresponding secretary.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

CUYAHOGA

Dr. Chester W. Jones, clinical professor of medicine, Harvard University Medical School, spoke on "Peptic Ulcer—Diagnostic and Therapeutic Considerations", at a meeting of the Cleveland Academy of Medicine, September 15, at the Medical Library Auditorium.

A combined meeting of the Academy's Internal Medicine Section and the Cleveland Neurological Society was held in the Herrick Room of the Medical Library, September 13. Dr. James H. Wall, assistant medical director, Westchester Division, New York Hospital, spoke on "Psychiatric Treatment of the Non-Psychotic Alcoholic".—Bulletin.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

SUMMIT

Charles S. Nelson, Columbus, Executive Secretary of the Ohio State Medical Association, addressed a joint meeting of the Summit County Medical Society and the Woman's Auxiliary, on the subject: "What Medicine Faces", September 12, at the Nurses' Home, Akron City Hospital. Members of the Auxiliary served refreshments after the meeting.—Bulletin.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D. PORTSMOUTH)

SCIOTO

At the regular monthly meeting of the Hempstead Academy of Medicine, September 11, at Portsmouth General Hospital, members enjoyed a colored talking picture from the Lahey Clinic on "Peptic Ulcer—Diagnosis and Treatment".—T. W. Frame, M.D., secretary.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

LORAIN

Dr. L. Howard Schriver, Cincinnati, President of the Ohio State Medical Association, was the speaker at a meeting of the Lorain County Medical Society, September 12, at Lorain.

RICHLAND

A meeting of the Richland County Medical Society was held at the Lockbourne Army Air Base, near Columbus, September 21. Major Paul Blackstone, Bellville, who is on duty at the station hospital at Lockbourne, was host to his former colleagues in an inspection tour of the base.—C. L. Hannum, M.D., secretary.

Coming Meetings

Ohio State Medical Association, Columbus, May 1-3, 1945.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 8-12.

American Hospital Association, Cleveland, Oct. 2-6.

Association of Military Surgeons of the United States, New York City, Nov. 2-4.

International College of Surgeons, United States Chapter, Philadelphia, Oct. 3-5.

Northwestern Ohio Medical Society, Findlay, Oct. 3.

Association of American Medical Colleges, Detroit, Oct. 23-25.

Inter-State Postgraduate Medical Association of North America, Chicago, Oct. 17-20.

Southern Medical Association, St. Louis, Nov. 13-16.

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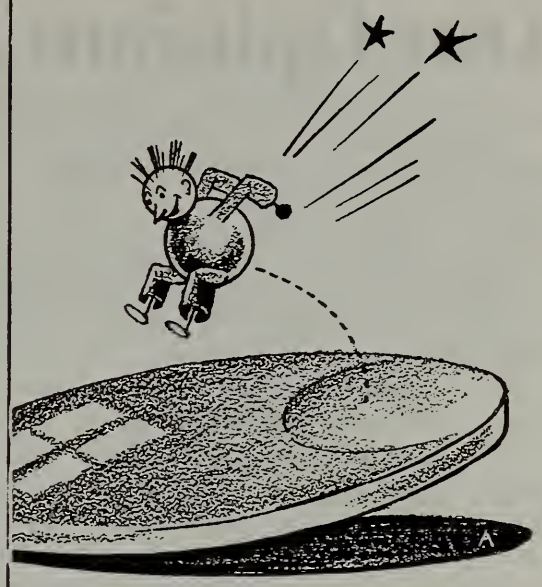
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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

THE ELECTION ON NOVEMBER 7 AND THE MEDICAL PROFESSION

On Tuesday, November 7, Ohio physicians, together with other citizens, will be expected to cast their votes for candidates for national, state and county offices.

There are a number of unusually significant things about this year's General Election.

The fact that the people of this country still have the right and opportunity to select their public officials—a right and opportunity which do not exist now in many lands—is something which should cause each voter of this country to pause and ponder. To preserve the system which provides such a right and opportunity should be an objective in the mind of each voter when he enters the polls on November 7.

Because of the vital issues involved, the November 7 election will be one of far-reaching importance and the result may cast the die for the social economy of this country for another generation at least.

Present indications are that the result of the election so far as it affects many candidates will be close. Interest in the election is intense despite the war. The largeness or smallness of the service men's vote also has added to the uncertainty.

So far as the medical profession is concerned, it has a bigger stake than ever in this election because the question of how and by whom medical and health services of the future shall be provided is one of the issues which has attracted widespread public attention.

Each physician knows the issues so it is not necessary to review them here.

Between now and November 7, each physician should determine in his own mind which candidates are best qualified for the offices to be filled; which candidates favor those principles and policies pertaining to government which are for the best interest of the public at large; which candidates are farsighted enough to realize that the health of the people can not be maintained or improved through the adoption of methods which would destroy standards and dilute the quality of health and medical services.

This point is of special importance: In evaluating candidates, don't overlook the fact that although the spotlight is at present on national issues, there are still vital state questions which must be considered.

For example, while it is important for you to know how candidates for public offices stand on the issue of governmental medicine, it is equally important for you to know how they stand on questions which directly affect public health in Ohio.

Will they vote against proposals which would tear down the Ohio Medical Practice Act and other statutes enacted for the protection of the public and the public health?

Will they refuse to yield to pressure from groups seeking unearned privileges through administrative decree?

In other words, will they support the medical profession in its efforts to maintain and preserve medical and health standards here in Ohio?

Before you actively support candidates for Ohio executive and legislative offices, find out the answers to these questions.

We can't afford to let the glamour of the national issues blind us so that we lose sight of those important issues which may arise right here in Ohio.

Those who do not have first-hand information on candidates should get this information from the officers and legislative committeemen of their county medical society. If they do not have the information, find out why. As a member, you have a right to expect this service from your society.

However, keep in mind that this can not be a one man job. Your officers and committeeman will need assistance in interviewing candidates and in assembling information for the membership. Volunteer your services for this important work. Every member should feel obligated to help.

After you have the information, put it to work. It is not enough just for physicians to be informed about candidates. Tell your friends, neighbors—your patients—about the candidates. You are just one vote. Your colleagues just a handful of votes, comparatively speaking. But, doctors see many people every day. If they will speak up and tell the people what they know, their influence will be great. To summarize:

Help get the information on candidates. Ask your county society officers and legislative committeeman for advice, based on the record or on interviews. See that the information you get is circulated where it will have effect.

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PHYSICIANS of the South have an urgent call to St. Louis for the annual meeting of the **Southern Medical Association,** Monday, Tuesday, Wednesday and Thursday, November 13-16 — **a great wartime meeting.** Medical meetings are essential, as essential in wartimes as in peace, even more so. Physicians, civilian and military, need medical meetings. At the St. Louis meeting, a streamlined essential wartime meeting, every phase of medicine and surgery will be covered in the general clinical sessions, the twenty sections, the four conjoint meetings, and the scientific and technical exhibits— **the last word in modern, practical, scientific medicine and surgery.** Addresses and papers will be given by distinguished physicians not only from the South but from other parts of the United States. Everything under one roof, the Municipal Auditorium.

REGARDLESS of what any physician may be interested in, regardless of how general or how limited his interest, there will be at St. Louis a program to challenge that interest and make it worth-while for him to attend.

ALL WHITE MEMBERS of the OHIO STATE MEDICAL ASSOCIATION are cordially invited to be the guests of the Southern Medical Association at the St. Louis meeting. Attending guests will be accorded every privilege of members except voting in business session. No registration fee. To secure program for the St. Louis meeting, write to

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RECOMMENDATIONS ON FEES AND RULES MADE TO COMMISSION

A comprehensive report, recommending changes in some of the Rules and Regulations of the Ohio Industrial Commission and many modifications in the Workmen's Compensation Medical and Surgical Fee Schedule, has been submitted by The Council of the Ohio State Medical Association to the Industrial Commission.

This report was prepared by the Committee on Workmen's Compensation. It was approved by The Council on September 9. Seven all-day meetings were held by the committee before the recommendations were drafted. Many suggestions were received from individual physicians, medical societies and specialty organizations. All were given studious consideration by the committee. Much help was received by the committee from officials of the various departments of the Commission, especially on matters relating to the rules and regulations. Dr. Robert Andre, supervisor, and Dr. Addison Kefauver, assistant supervisor, of the Medical Section, were especially helpful to the committee during its deliberations.

In this report, the Ohio State Medical Association, through The Council, has attempted to submit recommendations which are equitable to all parties concerned in the Workmen's Compensation System. During its deliberations, the committee, acting for The Council, had to arrive at compromises on some of the more controversial points. There will be differences of opinion with respect to some of the suggestions offered. Obviously, such a situation cannot be avoided in a large undertaking of this kind. It would be a miracle if the report met with unanimous approval on the part of all physicians. However, of one thing The Council and the committee are convinced: If the recommendations are put into effect by the Commission there will be a real improvement in procedures and the fees paid to physicians will be more equitable than those allowed under the present schedules.

It is the hope of The Council that the Commission will consider the report at an early date and that the recommendations submitted will be acted upon favorably. Such action by the Commission will certainly strengthen its relationship with the medical profession which, in the final analysis, plays a vital role in the operation of the Workmen's Compensation System.

Members of the Association are deeply indebted to the following members of the Committee on Workmen's Compensation for the thorough and conscientious work which they have done on this important project and for the sacrifices they made during the Summer months in attending so many conferences at Columbus: Dr. Barney J. Hein, Toledo, chairman; Dr. C. W. Dawson, Columbus; Dr. D. W. Heusinkveld, Cincinnati; Dr. J. Craig Bowman, Upper Sandusky; Dr. E. R. Bader, Cincinnati; Dr. James R. Driver, Cleveland; Dr. B. B. Sankey, Cleveland; Dr. L. N. Jentgen, Columbus; Dr. M. Paul Motto, Cleveland; Dr. John M. Van Dyke, Canton; and ex officio, President L. H. Schriver; President-Elect E. P. McNamee; and Past-President C. C. Sherburne.

TIPS FOR COUNTY SOCIETIES IN AUXILIARY OUTLINE

We have just finished reading a bulletin distributed to all Woman's Auxiliaries of county medical societies in Ohio, suggesting programs which might be presented by the auxiliaries during the coming year. The suggestions and outlines were prepared by a committee headed by Mrs. Ralph W. Hoffman, Columbus.

Here are some of the subjects, among others, suggested for discussion: "Legislative and Political Trends"; "A School Health Program"; "A Better Community Health Program"; "Medical

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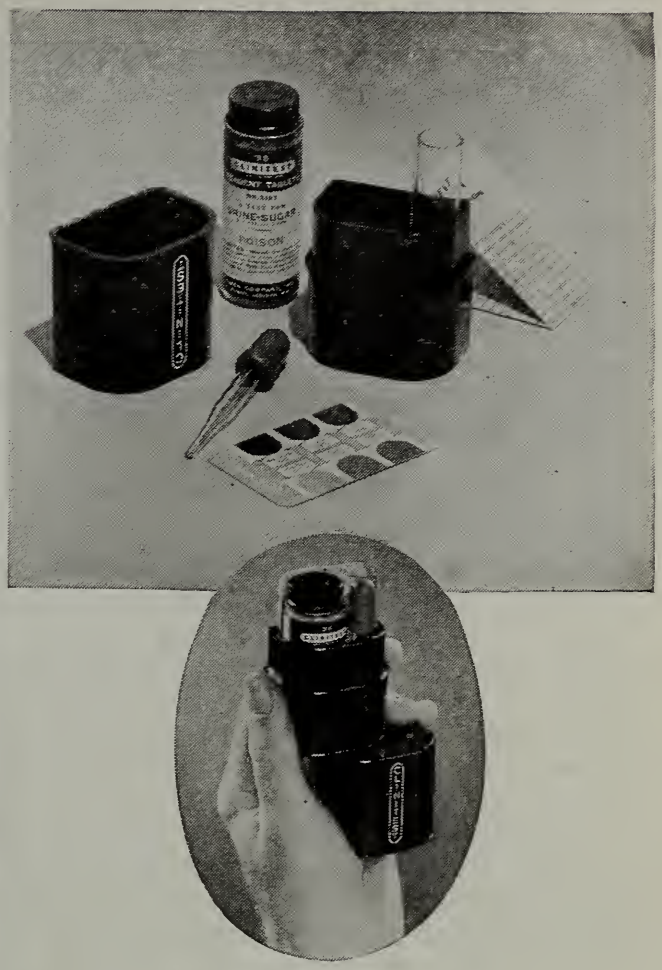
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Care for the Indigent"; "Health Insurance: Compulsory and Voluntary"; "Civic Housekeeping Institute". Suggestions regarding speakers and literature for study accompanied the bulletin.

This is a splendid job. The Woman's Auxiliary is to be congratulated on its initiative and enterprise.

In our opinion, some county medical societies might take a cue from this outline. If the subjects enumerated are worthwhile discussing at auxiliary meetings—and they are—then they are worthy subjects for discussion at county medical society meetings.

PEPPER COMMITTEE NEEDS CLOSE WATCHING

During recent weeks a Subcommittee on Wartime Health and Education, headed by Senator Pepper of Florida, has been holding hearings at Washington. According to Rilla Schroeder, writing in the *Survey Midmonthly*, "before the end of this Congress the subcommittee chairman, Pepper of Florida, will have a health bill ready for the Senate hopper".

The Wartime Service Bureau of the American Hospital Association, "reporting from Washington" to *Hospitals*, publication of the American Hospital Association, said regarding the Pepper Committee hearings:

"Subcommittee findings were submitted as a basis for the Democratic platform on social security presented at the Chicago convention. It is believed these same findings will also be used to form the basis for legislation to be introduced at some future date with the President's nod, as an alternate to S. 1161 (Wagner-Murray-Dingell). S. 1161 will be considered to have served its purpose in keeping the entire problem of hospital and medical care before the public and the professions, as well as to have absorbed some of their fire."

Now, who says the medical profession doesn't need a Washington office to keep the profession informed on what's going on there?

If the Wagner Bill is merely a smoke screen, it's time to find out where the real fire is—or will be. Unless Pepper has reformed, there is little likelihood that anything he will propose will be any better than the Wagner Bill.

Some of the testimony before his subcommittee which we have had an opportunity to review distorts the facts. Sure, there is plenty of opportunity for improvement of the nation's health. But, judging by the way some of the New Dealers, of whom Pepper is one, have messed up a lot of other things, we can't conceive that much they would do about it would have any beneficial effect.

It will behoove us to keep our eye on the Pepper committee.

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The Prevention of Industrial Dermatoses

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THE subject, "The Prevention of Industrial Dermatoses", if completely explored, would constitute a textbook. To review the subject within the limits of a paper will call for an understanding on the part of the reader that he is being offered only a description of general procedures, useful in their application but intended to serve only as a philosophical starting point for his techniques.

It must be stipulated that industrial dermatitis is sufficiently prevalent to justify the attention it is receiving. Anyone doubting this statement may refer to numerous statistical studies which bear it out. They are not quoted here because their auditory effect on an audience is likely to be one of cerebral desiccation. It must also be stipulated that any physician in industry, or rendering service to the industrially employed, must expect to face the dermatoses problem. Patients with dermatitis are too numerous to expect that they all may be treated by the trained dermatologist.

When a general practitioner resolves to screen his cases and refer only those which he finds obscure as to diagnosis, or resistant to treatment, to a dermatologist he is preparing to meet the demands of the dermatoses problem. If he further resolves that he will refer his difficult dermatitis patient to his specially trained colleague for consultation and advice, and that he will not terminate his interest and his curiosity when he has supplied the patient with the name and address of a specialist, he will find that the mysteries of dermatology begin to be revealed to him, and that even a pathological skin contains charms.

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Charming as the diagnosis and treatment of skin lesions may be, purer delight lies in the ability to control an epidemic, or lessen the prevalence of endemic industrial dermatitis. There will always remain sufficient skin lesions to satisfy the interest of the average physician. There are sufficient preventable types of industrial dermatoses to challenge his pride in preventive medicine.

There is no single measure which will prevent all industrial dermatitis. As a rule, more than one procedure or practice, is involved in the prevention of any given dermatitis. Five of the most important steps, by stretching the meaning of the words, begin with the letter "C". They are cleanliness, clothing, creams, change, and closure; the last being an engineering method rather than a medical one. By discussing each of these steps, I believe we can obtain a fairly complete bird's-eye view of the methods of prevention of industrial dermatoses.

CLEANLINESS

In view of the fact that we are dealing with skin irritants it is axiomatic that early and thorough removal of the substances from the skin, once they have been deposited, is a fundamental preventive step. This point is stressed because the practice is so frequently neglected. The ne-

cessity for frequent washing applies to clothing, which has accumulated the irritating substances, as well as to the skin. Thorough washing takes time and patience. The laundry difficulties of the nation have become the subject of comic cartoons, the humor of which lies in but slight exaggeration of every day actualities.

It is true that there is a tendency on the part of many employees to rush from work hurrying past the wash-room, or stopping only long enough for a dab of water and a swipe of a towel which would leave on the face of a ten-year-old boy an expression of glee, shining in a halo of dirt. Such neglect of personal hygiene encourages the production of dermatitis.

If this habit of personal neglect is newly-acquired due to the employee's begrudging the time required for washing, a moderate amount of education will result in improved practices. Where it is the reflection of life-time habits of neglect of cleanliness, a sterner insistence on personal hygiene is called for. Whatever approach is made in this matter must be made on an impersonal, uniform basis. The methods by which the employee is informed will vary in different concerns; it may be by bulletin, by a house organ, by direct word of mouth from supervisors, or by parallel methods. Whatever the method, the approach should be objective and the reasons for which cleanliness is particularly desired should be clearly outlined. It is only after such a campaign has been well under way that a personal approach to those who are neglecting the practice, should be considered necessary.

Unfortunately the lack of personal hygiene can not be entirely explained by the neglect of employees to use the washing facilities of the plant. There are a startling number of plants which supply such inadequate wash facilities that for practical purposes they may as well be considered as lacking entirely. No educational program to promote personal hygiene on the part of employees stands the remotest chance of success in the face of a lack of washing facilities. Its success is insured in direct ratio to the extent to which facilities are supplied. An adequate number of basins with cold water would be an improvement over present conditions in some plants. The addition of hot water is a further step. The supplying of soap begins to really raise the effectiveness of the plant standard, but it is only when towels as well are made available that real results can be expected.

We can paraphrase Mark Twain's expression when he first arrived in California. He said, "nothing adds to the charm of a river like water". We can tell an employer that nothing facilitates washing by an employee like water, soap, and a towel. This is predicated, of course, upon an original inclination to wash. Just how prevalent this desire is, can not be demonstrated until the necessary equipment is installed. I do not believe that any of you will have difficulty in convincing the management of a company which is subject to industrial dermatitis, that the installation of this equipment is a good investment. They may not have hitherto stopped to realize that it is the employee's skin only as long as it is healthy. The minute it is affected by occupational dermatitis, it is the employer's skin, as far as medical and compensation costs are concerned. He will gain a return on his investment in the prevention of dermatitis alone. The improved morale due to the installation of adequate washing facilities is a bonus.

At this time it must be emphasized that we are advocating the soap and water to keep a healthy skin clean. In the presence of some types of dermatitis, contra-indications to the use of soap may and do exist. This, however, belongs in the discussion of the treatment of dermatitis and does not fall within the scope of this paper.

We have mentioned soaps so frequently that some discussion should be made of them and of soap substitutes. There are so many soaps on the market that no one individual could give each a fair trial. There are some fundamentals, however which, if borne in mind, will simplify the selection of a suitable soap.

To begin with, a soap may or may not, have a "scrubber" added. A scrubber is any substance added to it to increase its effectiveness by supplying an element of friction. Any soap without a scrubber, such as ordinary toilet or liquid soap, may lather well and be quite satisfactory for ordinary household use. The worker who has been exposed to grime and grease all day, however, may find that such soaps are too slow or unsatisfactory for this purpose, so he turns to a soap with a scrubber. A simple scrubber is a cereal such as cornmeal, oatmeal, or beet pulp. Others are silicas and pumice. The harsher or coarser scrubbers are most effective in cleaning. Unfortunately, however, the greater may be the abrasive action on the skin. Since we are trying to protect skins which are already subject to assault, it will be seen that soaps with a strong abrasive action are to be used with caution.

There are powdered soaps which have no scrubber added but whose own crystals act as a scrubber before they are dissolved. A hand brush is a good scrubber, but again the condition of the individual skin must be considered.

It will be realized that the selection of an ideal soap is extremely difficult. Those ingredients or added measures, which increase its effectiveness as a cleanser, may also increase the potential danger to the skin. Consequently, effectiveness may have to be sacrificed for safety. In doubt, safety for the skin should have precedence

over rapidity of cleansing. Frequency of washing will allow the use of milder agents and this point should be emphasized in any educational campaign.

Strong alkalies or chemicals or disinfectants added to soap may be of such a nature as to cause irritation, and if their presence is suspected, an inquiry to the supplier, is in order. Formulas are not usually on the labels of soap. Most manufacturers are perfectly willing to answer any inquiries and assist in the selection of a satisfactory substitute if for any reason the one in use does prove to be unsuitable. This suggestion may save needless floundering and experimentation with materials.

Cornmeal was described as a good "scrubber". Lanolin has been recommended as useful in replacing the fat in the de-fatted dried-out skin. For this reason mixtures of cornmeal and soap with or without lanolin have been much used in recent years as a skin cleanser. Reports on its use seem to be unanimous in endorsing its effectiveness.

Recently the use of sulphonated castor oil has come into prominence as a skin cleanser. It consists of castor oil with sufficient sulphur to make it soluble in water, and a "wetting agent" added. The formula as published by Dr. Louis Schwartz, is 98 per cent sulphonated castor oil with the addition of 2 per cent Duponal. Indications are that it is most satisfactory for removing grease, oil and dirt. In spite of the fact that it does not lather, it is effective enough to have replaced the strong harmful solvents to which many machinists have habitually resorted in their efforts to remove grease rapidly. In addition, it, like the lanolin mentioned above, adds fat to the dried skin. In this respect, persons who are forced to work in solvents or oils who have excessively dry, de-fatted skin, will find it of advantage to apply some cream containing lanolin or olive or sweet oil to their hands before going to bed. The skin being de-fatted, will actually "drink" the oil from the skin and tend to regain its normal softness.

As a last remark in the matter of personal hygiene, it may be accepted that many employers even in the presence of dermatitis, will not feel that they are in a position to allow time off for washing but the firms which have done so, have proved their superior ability to obtain satisfactory results.

CLOTHING

We have already mentioned the necessity for keeping ordinary wearing apparel frequently laundered when it accumulates irritating substances. Since this is a matter greatly dependent upon the employee's domestic situation, it does not lend itself to direct supervision. It may be stressed in an educational campaign and it may also call for personal advice on the part of the physician. In some trades the irritant substances so impregnate the clothing, that work clothes or uniforms are supplied by the management and a change is required before leaving the plant, in which case the laundry service is a matter of managerial concern. Special types of protective clothing are supplied for special hazards and they vary from simple sleeves or aprons, up to complete suits, according to the required purposes.

If goggles are considered as wearing apparel, the clothing array is considerably increased. If masks are also so considered, the list of items becomes quite formidable. Masks vary from the simplest of gauze nose pieces, not dissimilar to the ether cone (and incidentally too frequently used for a purpose for which they are not approved), up to forced-air respirators, somewhat similar to a diver's helmet, and giving complete protection for practically any use.

The most important injunction to be laid down in the use of masks or respirators is that they be used only as a protection against the substances for which their protective features were designed and that they be not used for any other substance. The mask or respirator worn in the environment for which it was not designed to furnish protection, is more dangerous than no mask at all. The man without protection knows that he is unprotected; the man wearing an improper respirator is supplied with a false sense of security which may result in death.

May I caution any physician against thoughtlessly recommending the use of masks, or respirators, without adding the qualification "approved for this particular hazard".

CREAMS

The creams or lotions of various types offered by various manufacturers have flooded the market within the last few years. To attempt to describe and discuss the various types and their uses would hardly be justified in the space of this paper.

Since a number of reliable and established manufacturers have their products on the market, their advice as to the cream recommended for any purpose may be sought. Their claims unfortunately, may not always prove justified, but at least the percentage of successes should be higher than that achieved by blindly using any cream labeled "protective". All creams and lotions will have their limitations, both as to purpose and protective power. This point is emphasized because each problem may call for experimentation. Patience, as well as optimism, will be of value during the experimental period. It must also be borne in mind that too much can be ex-

pected of creams even when they are properly chosen. Certainly those who expect creams to replace the necessity for cleanliness are doomed to disappointment. As a matter of fact, we have more than a suspicion that one of the definite values of creams is the fact that they must be washed off, and at times the effective removal of irritants from the skin has been the by-product of an employee's intent to wash off the cream with which he has smeared his skin.

In contra-distinction to this difficulty in choosing a cream, the choice of a proper mask has been simplified by the Bureau of Mines, who have published a list of approved respiratory protective devices. These devices have passed exhaustive tests and offer protection against those exposures for which they were approved. Furthermore, each piece of such equipment has the Bureau of Mine's approval number attached or stamped on it.

We are not leaving the field of dermatitis in re-emphasizing the mask problem because the vapors of many solvents which produce asphyxia and death, also may produce dermatitis. In many cases it seems as though nature had provided a warning mechanism in the skin which caused withdrawal from the exposure and so prevented a continued inspiration or absorption which might have resulted in a serious systemic damage.

CHANGE

Change is an extremely useful technique in the prevention of industrial dermatitis. There are two types of change: one where the employee is changed to another environment; and the other, the change in the environment itself, making it compatible with the employee's welfare. We will speak particularly in this section of those changes which apply to personnel. Later we will discuss the engineering changes which aim to alter the environment.

There are cases where a complete withdrawal from the exposure is the only method by which a cure and prevention of recurrences can be obtained. Persons who are extremely sensitive either initially, or by a sensitivity acquired by a prolonged exposure, must be changed to a new environment. This may mean a change to another part of the same plant or it may require a change to a different industry entirely, if the exposure is one which is disseminated throughout the process.

In the average case of contact dermatitis, the conclusion that a change is inevitable should not be reached hastily, or at the first sign of dermatitis. It is generally true in many of common dermatitis producing situations, that persons automatically divide themselves into three groups:

1. The majority who show no reaction or a reaction too slight to cause any concern or to call for any treatment.
2. A number who develop the dermatitis usually within the first week or two of the exposure but in whom it never becomes severe enough to cause disability, or loss of time. Usually in the course of weeks or months these people become "hardened" or "toughened" and no longer show any reaction. They are the joy of the foreman in helping to keep new employees on the job because nothing is quite so convincing to the tenderfoot with early dermatitis as the smug and superior assurance of these old-timers, that, if they stick with it, everything will turn out all right.
3. The third class of people are those in whom the action is so severe that they must be removed from the work and lose time before they can be cured. If once apparently cured the condition recurs each time they return to work, then it must be accepted that their sensitivity is so great that a permanent removal from that environment is necessary.

Under "change" we might also mention the real final irrefutable test of the true industrial nature of dermatosis, that is, it recurs each time the exposure is duplicated and clears when the exposure is withdrawn. The true industrial dermatitis can be turned off and on like a water-tap by the job dispatcher, and its prevention in the very susceptible may depend on the co-operation of the employer in having the patient permanently assigned to another station.

There is one class of dermatosis encountered frequently in industry which is not truly industrial. Already "neuro-dermatitis" "atopic eczema", and some types of "nummular eczema", are being accepted as due to, or aggravated by, a psychic component. Textbooks and monographs are now beginning to appear on the re-discovered and newly-named art of psycho-somatic medicine. The skin manifestations of personalities that conflict with their environments are exceedingly frequent, and the possibility of this etiological factor is too seldom considered.

One of the old recipes on how to cook and serve a rabbit pie, gave as its first direction, "first shoot your rabbit". To maintain a high percentage of efficiency in the prevention of industrial dermatitis, be sure that the cause of the dermatitis is actually industrial. There is no use changing occupations in a middle-aged, over-weight, tense female, in an effort to cure her dermatitis if the actual cause is a domestic maladjustment. A transfer may cure such a condition in a person of either sex or any age, if the actual cause lies in the department in the

person of an unjust, unreasonable, or inadequate supervisor. If the patient is cured, the clinical result is still perfectly satisfactory, even if the real reason for the need of change has not been recognized. That fact that a dermatitis has been charged to an innocent exposure would not constitute the first incident on record where some pathology was attributed to industry without complete and perfect justification.

It is not our intention to imply that all atypical, as well as all atopic, dermatitis can be charged to a maladjusted love-life; or to dominating mothers-in-law. An over-enthusiastic indulgence in this type of speculation will result in more personal resentment toward a physician, than improvement in his patients, but, it is an etiological possibility which may well be borne in mind. It must be particularly remembered that the "nummular eczema" caused or aggravated by physic tension, is clinically simulated by that produced by low grade irritants, such as soap.

CLOSURE

Were is not for our effort at alliteration we might well call this subheading, "enclosure and exhaust". As previously stated, it is purely an engineering program and let the doctor who thinks that the stethoscope and slide rule are interchangeable in the same hands, beware. Nevertheless, he must keep in mind that cleanliness, special clothing, and creams are not adequate protection against an atmosphere whose gross contamination is so heavy that it must be controlled by engineering methods.

In some cases the whole process can be enclosed with perfect efficiency; in other cases an efficient exhaust system is necessary to remove the dust, the fume, the vapor, or gas from the atmosphere. In others, a combination of the two methods may be required. It might be well for the doctor to go no further than to advise that the possibility of controlling these exposures by engineering methods be explored by the employer. Both the enclosing of processes and the installation of exhaust ventilation equipment are expensive. If there must be any monuments erected to improper design or operation, I feel it preferable that the Rube Goldbergs, who are to be so long remembered by those who have paid the bill, should be recruited from other ranks than the medical profession. Competent engineering advice can be expected and obtained from competent engineers. The ten easy lessons entitled, "Industrial Engineering for Doctors", have not yet been written.

Not all problems in engineering of course have to be referred to a National Planning Board. Numerous examples of clever and effective improvising can be found. In one plant a dermatitis was being produced on the hands, arms, faces, and necks of girls, who ground off the excess margins of some rubber composition insulating equipment. The instrument used was a hand motor which revolved a large burr, like a dentist's drill, an inch in diameter. Since the side of the burr was used, the revolutions sprayed the exposed portions of the operator's skin. A profound consultation was held as to the mechanical means which might be used for protection. The plant management had noticed that the left-handed girls, by holding the drill in a reverse position, sprayed the dust away from them. They met the situation by employing only left-handed girls for this operation regardless of their color, complexion, texture of skin, state of allergy, or their heredity. Another dermatitis problem was solved.

In another case, there was some serious question as to whether the large fans which were installed would adequately exhaust the fumes of a furnace, which were known to be toxic to both the skin and to the general system, if allowed to accumulate. The conventional way of estimating the efficiency of these fans would have been by the use of some measurements, a slide rule, and a set of mathematical tables. It would have called for some outside and possibly expensive consultation. Actually the representatives of the management scoured the plant yard and gathered up a lot of chips, sticks, lumber, wrapping paper, tar paper, and green grass. They laid an enormous bonfire of everything inflammable, and on top of it piled the material which would create smoke. They figured that if the fans would keep the smoke from emanating through the door into the passageway, and from there to the rest of the plant, that the exhaust system was efficient. When everything was burning merrily and smoking stupendously they escaped into the passageway and waited. No smoke followed them and they concluded, apparently quite soundly that their exhaust system was efficient.

We may now consider a few applications to illustrate the uses of these various methods. For the ubiquitous cutting oil dermatitis, our chief protection is cleanliness. This may be reinforced by the use of creams and by special synthetic rubber aprons or other clothing, when splash can not be controlled mechanically. A change of station is required where the case is severe or stubborn, and an engineering change in the constituents of the oil may be necessary where the chlorine or other dermatitis-producing ingredients are excessive. The guards against splashing constitute a partial enclosure.

The prevention of dermatitis by tetryl dust is another example of the necessity for using all techniques; the particular need for cleanliness has developed soaps of special formula to remove the tetryl from the skin, as the conventional soaps leave a sufficient residue to produce a

dermatitis. Special clothing consisting of gloves, sleeves, and aprons are used, as well as protective ointment. Change of stations are necessary because individual susceptibility to tetryl varies considerably. Change of uniforms before leaving work is likely to be compulsory. Exhaust ventilation and partial enclosures are used to the fullest extent possible.

An excellent example of a hazard controlled chiefly by partial enclosures and exhaust, is that in degreasing operations, where parts are immersed in chlorinated hydrocarbons such as carbon-tetrachloride and tri-chlorethylene. These solvents offer both a skin and a respiratory hazard. These tanks are likely to have cooling coils above the level of the liquid which cause condensation of the fumes, exhaust ventilation at the lip of the tank, a cover which is used when material is not being lifted in or out, and the speed of removal of the parts is slowed to allow evaporation and draining to take place within the tank, rather than in the atmosphere.

An even more frequent example are the tanks used for plating or cleaning, where partial enclosures, by means of canopied hoods, prevent atmospheric contamination sufficient to cause dermatitis.

For those who are interested in seeing "exhaust ventilation" in efficient operation for the prevention of dermatitis as well as systemic damage, a prearranged visit to the nearest airplane plant will usually demonstrate spray booths with efficient air exhaust ventilation in operation.

The discussion on the prevention of dermatitis would not be complete without reference to the physiological mechanics of its production. In many types of occupational dermatoses, contact allergy plays an important role. Contact allergy is an extremely reasonable explanation for a dermatitis produced in a few individuals by an exposure shared equally with many fellow employees who develop no dermatitis. In cases of extreme sensitivity, a dermatitis may be produced by an exposure infinitesimal compared to that which leaves the normal individual unaffected.

It is essential to realize however, that there are many dermatoses produced by substances which are primary cutaneous irritants, which in sufficient strength will cause damage to any skin, without the slightest element of allergy being involved. Examples of these substances are alkalies, strong acids, or caustic salts. We for instance, do not consider that the child who burns his oesophagus by drinking lye must have inherited a sensitivity to alkalis from his maternal grandparents. Neither does it occur to us that the chemist who upset a bottle of nitric acid, should be patch tested because he burned both his skin and his trousers.

The situation grows more complicated when we consider that some people may possess a contact allergy to a primary cutaneous irritant. This may be suspected when the reaction is far out of proportion to that which is experienced by those who share an equal or greater exposure. This must be borne in mind when patch tests are used. In patch testing with a primary irritant, it absolutely must be diluted below that strength which will produce a reaction on normal skin.

We may conclude that it is not sufficient to identify the agent producing the dermatitis, but it is also necessary to know something as to the concentration or amount, of the exposure. In other words, not only do individuals vary in their reactions to irritants but the quality and the quantity of the irritant influence the reaction. We may generalize that an extremely toxic agent may be handled with impunity when the process is controlled and the exposure to the individual kept within safe limits. Where this ideal can not be realized, an emloyee may be protected against a dangerous exposure by means of personal protective measures. The corollary of this is, that a relatively innocuous substance may be handled so carelessly that an employee literally wallows in it, and as a result his status may be changed from that of an active healthy worker, into that of a statistic in a Table of Dermatitis Frequency in Industry.

Sayings of a Psychiatrist

Joseph L. Fetterman, M.D., F.A.P.A.

The problem of an amputee begins where surgery ends.

* * *

The fate of an amputee depends more upon his personality than upon his pathology.

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To assist the handicapped veteran patronize his business not his illness.

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The most fatigued are those tired of life.

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Man lives not by calories alone, but by culture and conscience.

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Fears are foremost among the ills of mankind.

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Beware of words which take the place of worth.

* * *

Judge a physician on his aptitude not his apparatus.

* * *

Diet Note: A second helping leads to a double chin.

* * *

Vehicles are a greater threat to children than viruses. More are crippled by auto injuries than by infantile paralysis. Train your children to feel instinctively that curb means caution.

Disqualifying Pulmonary Defects in 100,000 Selectees Examined Radiographically by an Armed Forces Induction Station*

MINER W. SEYMOUR M. D.

STANDARDS

M.R. 1-9, as amended and changed from time to time, has been the only set of standards used in determining a selectee's fitness for miltary service. As applied to pulmonary pathology only general service and rejection are authorized, no limited service has been in effect for the past 14 months. These regulations state as follows: "The chest examination will include a roentgenogram, as well as the usual methods of physical diagnosis"—"A pertinent history of past chest diseases will be taken"—"Chest X-ray made on individuals entering the military service are to serve as permanent records."

All chest pathology has been interpreted as to the man's ability to do general military service and as to any possible future clinical significance both to the man and to the government, from a financial and hospitalization viewpoint. It is of course realized that many borderline chest lesions, both tuberculous and non-tuberculous, will probably not become disabling in normal civilian life, but may be significant under the hardships of a military action.

Tuberculous lesions are divided into two groups. Primary, with resultant parenchymal and hilar pulmonary calcifications, are of much less future significance and therefore are treated with some leniency. In individuals of the group 18 to 25 years of age these lesions are rejectable if any parenchymal calcification exceeds 0.5 cm., or if any hilar calcification exceeds 1.0 cm. They are also rejectable if the total parenchymal number exceeds ten, or if the total hilar number exceeds five. However in the group over 25 years of age any primary calcified residual is acceptable if definitely inactive from an X-ray, physical examination, and history standpoint.

In either age group questionable stability is checked at this station by deferring the registrant for a minimum period of six months, at which time the roentgenograms are compared for changes in the lesions. It must be borne in mind that any change, either progression or regression, shows instability and disqualifies the man for military duty. It is realized that six months is not always a long enough period to determine stability in these lesions. A second six months' deferral may be used in those cases whose lesions are still questionable.

Reinfection type tuberculosis in any stage or degree is non-acceptable, with the exception of the occasional cases in individuals over 25 years of age who have small areas of fibrous scarring (not exceeding five square cm.) which have been proven inactive by a six months' recheck. So called "arrested" cases are not taken for military duty if any degree of reinfection tuberculosis is demonstrable on the X-ray and if there is a history of a positive sputum. Many men give a history of "tuberculosis" without specific treatment, and with no demonstrable lesion on the X-ray; this history is necessarily discounted and the man is considered acceptable.

Other pulmonary defects in great variety are seen. These must be evaluated as to their disabling characteristics and future clinical significance in military life. The three commonest are bronchiectasis, silicosis, and thickened pleura.

Bronchiectasis must be moderately advanced and extensive to be seen on the flat plate and always a history of prolonged chronic cough, productive in the mornings, is obtained. These men from the chronicity and annoying character of their disease are disqualified.

Silicosis is evidenced by strandlike nodular fibrosis in the X-ray and is always confirmed by a history of occupational exposure. Due to the reduced vital capacity these men demonstrate, and their increased susceptibility to pulmonary infection, they are disqualifed.

Thickened pleura is, in itself, not clinically significant and up to a moderate degree is acceptable, but if extensive enough to cover a fairly large amount of lung is rejectable on the basis that there is no way to evaluate the underlying lung structure.

From time to time certain changes have been made in the regulations. These primarily have tended to liberalize the acceptance of calcified

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The Author

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residuals of primary tuberculosis. In addition a paragraph was added giving the roentgenologist greater latitude in interpreting chest lesions. However these changes have had no effect on the total pulmonary reject percentage at this station, due to the forwarding for re-examination, by the local boards, previous rejects who are again rejected.

There has been recently established under Ohio Selective Service a "Special Medical Advisory Board" for the purpose of reviewing the films of registrants rejected for pulmonary causes. This board consists of three civilian physicians qualified in tuberculosis and one army roentgenologist (the author) and it acts for the entire state of Ohio. Meetings are held every two weeks at which time all films of registrants rejected for pulmonary pathology, who reside in Ohio, are reviewed.

This board recommends that selectees whose lesions they consider acceptable or borderline be reconsidered by the induction stations either at once or after a deferment period of six months. The board realizes the limitations of X-ray alone and the acceptance of these men is left entirely to the discretion of the induction station after further history, careful physical examination, and further X-ray studies have been made. By this method of double checking pulmonary rejects, few men are disqualified with chest pathology which is acceptable to the armed forces, and borderline cases receive the opinion of more than one roentgenologist, thus protecting the services from clinically significant lesions.

METHODS

A. Paper films:

The first 68,045 roentgenograms included in this study were taken on 14 x 17, single, paper film. This service was furnished the army by the Powers X-ray Corporation of Glen Cove, New York. This company furnished all personnel for the taking and processing of the films, furnished all supplies and equipment and guaranteed a diagnostic X-ray on each registrant.

The drying, labeling, filing and distribution of the film was the responsibility of the Army and was done by Army personnel. This film was read wet by reflected light arranged so as to avoid glare and surface reflection. A tube-screen distance of 48 inches was used on a portable unit designed by the company. The subject was positioned in front of a stationary tube and cassette by means of steps to regulate his height. A technic of 100 M.A.—70-90 KVP, and 0.1-0.15 seconds was used and gave good penetration and contrast on all except the heaviest men. Personnel consisted of one technician, who positioned and radiographed each man, and two or three dark room men who processed the films. Film was supplied in rolls of 100 which was cut off by a draw knife in the cassette after each exposure.

By this process the rate of flow was approximately 125-150 men per hour through the department with an elapsed time of 20-30 minutes between the radiographing of the men and the reporting of his film. Retakes averaged about 2 per 100 and were primarily due to faulty dark room technic. At the outset these films were eminently satisfactory but their quality deteriorated somewhat during the last few months, not through any fault of the process, but due to the difficulty of the company in maintaining trained personnel on these jobs since they were non-deferrable by selective service.

The diagnostic value of these paper films was felt to be good. Each roentgenologist when first starting to read them had some difficulty due to the paper's tendency to accentuate normal markings and to give a somewhat "soft" appearance to lesions. However, after becoming accustomed to them the film was felt to be equally diagnostic when compared with 14 x 17 transparent films. The paper films had the additional advantage of ease and speed of handling since they were tray developed in bunches of 20 to 30. The rejection rate was on an average with areas using other processes.

B. Photoroentgenography:

The remaining 31,955 films included in this report were taken by the General Electric photoroentgen unit as 4 x 5 stero pictures on the 4 x 10 film. Two units are installed at this station and are manned by seven Army technicians, two in each exposure room, and three in the dark room. Several radiographic technics have been tried, and the final one in use for the past 25,000 men consisting of 36 inch tube-screen distance, 150 M.A. 80—100 KVP at 0.2 to 0.3 seconds. Any extremely thick man (over 28 cm.) is X-rayed on 14 x 17 single film to conserve the tube life of the photoroentgen unit.

Only one of the seven technicians had had previous X-ray experience; so a school was instituted with lectures, demonstrations and practical work and their work is now eminently satisfactory. Regular rotation is practiced among all the positions both to avoid over exposure to X-ray and to insure each man's knowledge of all jobs.

The rate of flow, using the two units, is 130-150 men per hour through the department and there is an average elapsed time of one hour between the exposure and reporting of the film. The drying of the film has presented the most difficulty, and a rack, holding 150 films in clips, over which air is forced by several large fans, has proven the most satisfactory method. Dust is carefully avoided in the drying room. Tube life on these units has been averaging 18,000 exposures and retakes average less than 1 per 100.

The diagnostic value of these films is good and

the stereoscopic image has some advantage over the flat plate. Each film is read flat and in stereoscopic to avoid as much personal error as possible. It has been found necessary to take 14 x 17 conventional stereoscopics on about 1 man per 100 to disprove or prove pulmonary pathology. When the 4 x 5 stereoscopics were first used the rejection rate rose about 0.5 per cent but soon again fell to the previous level found on paper films. This was probably due to the roentgenologist's unfamiliarity with the new process. Lesions tend to look "softer" on the 4 x 5 stereoscopics than on the conventional 14 x 17. But they are as easily seen as to position and extent, with the possible exception of the apices, which are somewhat harder to read than on the larger film.

The two processes used by this station may be compared as follows:

	Paper Film	4 x 5 Stereoscopic
Diagnostic Value	Good	Good (stereoscopic advantage)
Speed per unit	125-150 per 1 hr.	65-75 per 1 hr. (each unit)
Personnel	4 men	4 men (each unit)
Retakes	3/100	2/100
Filing	Hard & Bulky	Easy and Compact
Tube life	30-40,000 Exposures	18,000 exposures
Eye Fatigue	Little	Moderate

All intrathoracic tuberculosis is reported and entered on the physical examination form DSS 221. This includes all calcified residuals of primary lesions as well as disqualifying types. Thus a permanent record is made of the type and extent of all non-disqualifying lesions for the future protection of the government. Intimate liaison is maintained with the examiners in the heart and lung room who take histories of previous pulmonary disease and submit this information to the roentgenologist for use when the plates are interpreted. In addition questionable pathology seen on the X-rays is given these examiners to aid their physical examinations.

INTERPRETATION

The history of the selectee is carefully taken in all questionable cases and confirmatory evidence such as physicians' reports, previous X-rays, and laboratory studies is requested and evaluated in the light of the X-ray findings. However the mere statement of the selectee that he has had tuberculosis is discounted in the presence of a negative X-ray. Excellent cooperation is obtained from the Franklin County (Ohio) Tuberculosis Controller in locating and making available for use any previous tuberculosis data on men from this county. Also, active reinfection cases found at this station are given to him through the Ohio State Selective Service Headquarters for follow-up from a public health standpoint.

TYPES OF SELECTEES

The men covered in this survey are divided nearly equally between urban (Columbus, Dayton, Zanesville, etc.) and rural dwellers. About 10 per cent are from the mining communities of Southern Ohio. A considerable number have been seen for a second examination and a few for the third and fourth time. These duplications raise the percentage of rejections to some slight degree. The age group was at first 21 to 45 years but was then lowered to the 18 to 38 years of age. No significant statistical variation was seen between the two groups since the bulk of the men were common to both groups (21-38 years).

There has been a striking amount of pulmonary pathology seen in the registrants rejected for neuro-psychiatric reasons. Predominately this has been in the mentally deficient group and may be at least partially due to the poor hygienic habits of such persons. A correlation of these factors is being followed statistically by our neuro-psychiatric group.

About 7 per cent of the selectees were colored, predominately from the urban areas, and their rejections for pulmonary reasons averaged about 1 per cent higher than in the white group.

TUBERCULOUS REJECTS

A. Primary Phase:

The number of calcified primary residuals seen at this station is extremely high. Better than 30 per cent of the men X-rayed showed either hilar or parenchymal calcification or both. However the great majority of these are not clinically significant and are acceptable under existing regulations. Only one per cent of the men had primary tuberculosis which was considered rejectable. Of this per cent only 0.06 per cent had what was considered a possibly active primary focus. Another 0.43 per cent had stable primary residuals which were too extensive for induction under existing regulations. This number consisted nearly entirely of the group 18 to 25 years of age since over 25 years of age much more leniency is shown in accepting primary calcifications.

The remainder (or 0.5 per cent of the primary phase group) had questionably stable primary lesions which were deferred a minimum of six months at this station in order to determine to some degree their inactivity by comparison films. Of this group returned for re-examination 92 per cent were found acceptable since the lesions showed no change on the comparison films. Those whose calcifications were still of a questionable nature were again deferred for a further six-month period.

B. Reinfection Phase:

As has been stated practically none of this group are acceptable for military service with the exception of the very few who show only a small

TABLE I

SUMMARY OF 100,000 PULMONARY X-RAYS ON SELECTEES

Month	Men X-rayed	Total Pulmonary Rejects		Rejected for Tuberculous Lesions		Primary Phase Tuberculosis						Reinfection Tuberculous Lesions				Pulmonary Rejected for other than Tuberculosis	
						Active		Extensive Stable		Question Defer 6 Mo.		Minimal Act. Undet.		Advanced			
	No.	Men	Per Cent	Men	Per Cent	Men	Per Cent	Men	Per Cent	Men	Per Cent	Men	Per Cent	Men	Per Cent	Men	Per Cent
1942																	
August	6,955	182	2.62	133	1.91	5	0.07	18	0.25	35	0.49	65	0.91	10	0.14	49	0.71
September	5,940	145	2.44	108	1.94	1	1.01	25	0.37	35	0.45	40	0.52	7	0.09	37	0.50
October	10,069	256	2.55	187	1.86	7	0.07	53	0.53	7	0.07	107	1.07	13	0.13	68	0.68
November	8,171	223	2.73	177	2.16	8	0.09	19	0.23	26	0.31	111	1.33	13	0.19	46	0.57
December	5,895	158	2.67	131	2.24	3	0.05	18	0.29	35	0.56	65	1.04	10	0.16	27	0.43
1943																	
January	8,095	190	2.32	154	1.87	1	0.01	38	0.49	37	0.47	69	0.88	9	0.12	36	0.45
February	7,504	201	2.62	161	2.09	2	0.03	25	0.33	62	0.79	66	0.87	6	0.08	40	0.53
March	9,286	223	2.41	169	1.84	7	0.14	40	0.42	56	0.58	63	0.64	3	0.06	54	0.57
April	6,035	152	2.35	121	1.83	1	0.01	43	0.64	31	0.44	40	0.62	6	0.10	31	0.57
May	5,973	117	1.96	98	1.64	12	0.29	20	0.35	27	0.47	32	0.49	7	0.12	19	0.32
June	6,040	132	2.18	109	1.80	7	0.11	26	0.42	5	0.09	66	1.09	5	0.09	23	0.38
July	5,644	154	2.72	133	2.35	6	0.10	32	0.52	16	0.24	63	1.44	16	0.52	21	0.37
August	6,805	172	2.52	145	2.11	2	0.03	40	0.59	53	0.75	37	0.53	13	0.19	27	0.42
September	6,102	161	2.63	140	2.29	1	0.16	25	0.41	63	1.02	41	0.67	10	0.16	21	0.34
October 1-5	1,486	39	2.62	36	2.42	1	0.07	5	0.34	19	1.27	10	0.67	1	0.07	3	0.20
Totals	100,000	2505	2.50	2002	2.00	64	0.06	427	0.43	507	0.51	875	0.87	129	0.13	503	0.50

area of linear fibrosis not exceeding 5 square cm. which has been proven inactive by comparison films. For convenience the reinfection phase was dicided into (1) minimal lesions, activity undetermined and (2) advanced, presumably active. One per cent of the men examined had reinfection phase tuberculosis in some stage. Of these 0.87 per cent were considered minimal lesions whose activity was undetermined, and 0.13 per cent were advanced with cavitation or honeycombing. Of this total percentage, 35 per cent had other causes for rejection which would have prevented their entering the service, the remainder—65 per cent of 652 men—were saved from induction and therefore 652 tuberculous contacts prevented in military service.

In addition future claims against the government were avoided and hospitalization at government expense was reduced. There is no way as yet to estimate the amount of error, both from personal and technical reasons, found in this study. How many men have been inducted with pulmonary pathology, who should have been rejected, it is impossible to state. However, the reports of men separated from the service, by medical discharge due to these causes, has been extremely small.

Table I shows the complete statistics gathered for the pulmonary rejects summarized in this paper. It is seen that there is no seasonal variation and there has been little significant change as the drafting of selectees has proceeded over a period of 15 months. The only variation has been in the rejection rate for non-tuberculous pathology which fell after the dropping of the 38 to 45 years of age group.

Table II lists the non-tuberculous causes of rejection seen.

VALUE OF THE SURVEY PROCEDURE

From the figures of World War I, each man kept out of military service because of tuberculosis represents a net saving to the govern-

TABLE II

NON-TUBERCULOUS CAUSES FOR REJECTION FOUND IN 100,000 SELECTEES RADIOGRAPHS

Cause	Number	Per Cent
Bronchiectasis	128	0.128
Silicosis (Pneumoconiosis)	68	0.068
Thickened Pleura	95	0.095
Generalized Pulmonary Fibrosis	23	0.023
Hilar Enlargement (No Calcification)	20	0.020
Enlarged Peri-Tracheal Node	21	0.021
Chronic Bronchitis	16	0.016
Acute Pneumonitis	15	0.015
Emphysema	12	0.012
Pneumothorax (Spontaneous)	12	0.012
Old Empyema Residuals Extensive	11	0.011
Pleural Effusion (Cause Undetermined)	8	0.008
Foreign Object (Bronchial or Pulmonary)	7	0.007
Mediastinal Tumor (Type Undetermined)	6	0.006
Lung Parenchymal Tumor	6	0.006
Acute Bronchitis (Deferred)	6	0.006
Diaphragmatic Eventration	6	0.006
Cystic Disease of the Lung	6	0.006
Calcified Pleura (Extensive)	6	0.006
Paralysis of the Diaphragm	4	0.004
Residual of Old Lung Abscess	3	0.003
Dermod Cyst of the Lung	3	0.003
Metastatic Carcinoma	2	0.002
Lobar Pneumonia	2	0.002
Mycotic Disease (Monilia & Aspergillum)	2	0.002
Lobectomy	2	0.002
Mediastinal Hodgkins Disease	2	0.002
Thoracoplasty	1	0.001
Diaphragmatic Hernia	1	0.001
Atelectasis	1	0.001
Massive Calcified Cervical Nodes	1	0.001
Traumatic Scarring of the Lung	1	0.001
Permanent Traumatic Pneumothorax	1	0.001
Multiple Tumors of the Ribs	1	0.001
Marked Anamoly of the Diaphragm	1	0.001
Substernal Thyroid	1	0.001
Recent Lipiodalization (Deferred)	1	0.001
Beck's Sarcoidosis	1	0.001
Total	503	0.503

ment of $10,000 to $15,000, discounting the care of possible contacts who might have developed the disease. In the 20-year interim between the

two wars the government spent more than $1,000,000,000 for the care of tuberculous veterans. The cost of the chest roentgenograms on the present army can not approach this figure. In addition the contribution to the civilian health should be considerable in that the men discovered with tuberculosis return to society with a knowledge of their disease and the great majority will seek treatment. Also it is an excellent opportunity for public health officials interested in tuberculosis control to list a great many new cases for protection of contacts and treatment.

New methods of X-ray screening are being improved by army usage for both paper roll film method and photoroentgenograph. Finally, in the future surveys, expected case finding figures can be predicted, in the selective service age group, by the use of the present tremendous number of men being X-rayed by the armed services and from the tuberculosis rate found in these men.

SUMMARY

1. 100,000 chest X-rays are summarized as to pulmonary pathology found.
2. Two methods of rapid chest survey were used and compared.
3. Statistical data are presented on tuberculous and non-tuberculous defects, disqualifying for military service, that were found.
4. Comments are made on the present and future significance of such studies.

The Medical Management of Jaundice

The role of vitamins in the management of jaundice patients can be looked upon from two angles. First from the point of view that the vitamins protect the liver and help in its repair and, secondly, that the liver influences vitamin metabolism since the liver represents the most important store for many vitamins. Animal experiments indicate that in the unidentified parts of the vitamin B complex there are substances which are necessary for adequate functioning of the liver and successful treatment of liver cirrhosis has been reported by nutritious diet and supplements rich in vitamin B-complex. Consequently in the treatment of jaundice, crude vitamin B-complex preparations are indicated from which these unidentified parts have not been removed. As long as these fractions are not known it is best to feed the patients yeast powder, 2-3 ounces daily, preferably in tomato juice. Only in cases where yeast is not tolerated B-complex preparations may be used. For parenteral administration crude, highly colored liver extract is preferable. The high potency concentrated liver preparations used in the treatment of pernicious anemia have possibly lost these B-complex factors.—Frederick Steigmann, M.D., and Hans Popper, M.D., Chicago. Ill. Med. Jr., Vol. 86, No. 3, Sept., 1944.

Disease Prevention

"To understand the state presented by any individual or group, one must have complete specification of the conditions producing that state. Causes never are simple; they always involve a number of necessary conditions which together comprise sufficient conditions leading to the effect they together cause. E.g., pellagra is not due to a deficient diet of a certain kind; such a deficient diet is only one condition involved in the production of that disease. Other conditions must be considered as necessary in specifying the cause of pellagra, and these are essentially of a socio-economic nature, primarily leading to a deficient diet which, in turn, leads to the dreadful disease. Above the poverty line, pellagra is unknown. Hence in pellagra, it may justly be said that the most important factors are socio-economic.

"This example is discussed to illustrate that in medicine the tendency is strongly entrenched to think of the diagnosis and cure of disease in terms of specific knowledge of the meaning of symptoms and the physical means of alleviating them, giving little or no thought to the socio-economic factors which produced them and which are likely to cause them to recur. Improved socio-economic conditions have done as much as, if not more than, biologic and medical discovery to reduce disease. In cannot be too greatly emphasized that 'improved socio-economic conditions' are always the improved socio-economic conditions of, and as they affect, the individual—and hence, the group. Improvements this way do not operate simply in a vacuum. Furthermore, problems of disease and public health are essentially socio-economic, and only secondarily medical problems. This truth, after long and painful experience, was forced on Rudolf Virchow, who declared: 'Medicine is a social science'. It is a truth which the physician must ever keep before him; that alleviation of disease will never succeed in eliminating disease but that improvement in socio-economic conditions will."—Montagu, Medical Physics, p. 1015, Year Book Publishers, Inc. 1944.

Cardiac Disorders

While the murmur will often disappear at the end of inspiration if the breath is held, in other cases the murmur fades away gradually over three or four cardiac cycles when the breath is held. The cardio-respiratory murmurs usually disappear either immediately or shortly after the breath is held at full inspiration. If the murmur refuses to follow this rule one may find that it varies in intensity at certain phases of respiration.—Col. John T. Kind, M.C., Washington, D.C., Journal of Missouri State Medical Assn., Vol. 41, No. 10, Oct., 1944.

Intestinal Parasitism In Cleveland City Hospital, 1939-1944*

WILLIAM D. DAVIS, M.D., and ROY W. SCOTT, M.D.

THE diagnois and treatment of parasitic diseases while taught in all medical schools are seldom thought of in routine hospital study throughout most of the Mid-Western and Eastern states. The frequency of these diseases deserves much more attention than is usually given them, particularly since recent studies[1,2,3] emphasize their relatively common occurrence.

Furthermore, the return of members of the armed forces of the United States from many tropical and sub-tropical regions necessitates further familiarity with these and other tropical diseases.

Therefore, it seems pertinent to review the cases of intestinal parasites diagnosed in a large municipal hospital.

Since January 1, 1939, there have been 52 cases of infestation with intestinal parasites diagnosed in Cleveland City Hospital,—an incidence of about 0.08 per cent. An analysis of the occurrence (Table 1) shows that with two outstanding exceptions occurrence by years has been fairly uniform, 12 cases being diagnosed in 1939, 14 in 1940, 8 each in 1941 and 1942, and 13 in 1943-1944. In this respect it is interesting to note the yearly decline of diagnosis of tapeworm infestation and the apparent absence of amebiasis from 1939 to 1943. The variety of parasites is fairly representative although strongyloides stercoralis, fish tape worm, and dwarf tape worm are not found.

TABLE 1—OCCURRENCE

Parasite	1939	1940	1941	1942	1943-44
Enterobius	3	6	4	5	7
of intestine	1	3	2	3	6
of appendix	2	3	2	2	1
T. Saginata	7	4	2	0	0
T. Solium	0	0	1	0	0
T. Echinococcus	0	0	0	1	0
Ascaris L.	2	2	0	1	2
T. Spiralis	0	2	1	1	0
E. Histolytica	0	0	0	0	3
Giardia Lamblia	0	0	0	0	1
Totals	12	14	8	8	13

MOST COMMON INFESTATION

The most common infestation was that of pinworm or seat worm, enterobius vermicularis. This is entirely in accord as it is certainly the most common helminthic parasite of man.

Cram[2] in 1937 found 35.4 per cent of 1,272 persons in Washington, D. C., infested with pinworms. Jacobs[3] found 31.3 per cent of 228 children examined in Out-Patients clinics infested.

At Cleveland City Hospital during the period under consideration 23 (Table 2) cases of enterobius infestation were recorded and of these 13 were intestinal and 10 appendiceal. Most of the intestinal cases were in small children; and none was over 15 years of age. Twelve of the 15 were six years of age and under. There were 12 white children and one negro; nine were female and four were male. A positive history was noted in eight of the cases and curiously enough the diagnosis was suspected in only seven.

The symptomatology was varied and for the most part quite mild. Restlessness, irritability, vague abdominal uneasiness, and failure to gain weight were the most frequent manifestations. Anal swabbing or stool analysis in an attempt to substantiate a diagnosis were done in eight cases, with six positive results obtained. Repeated examinations were done in five cases.

TREATMENT

The treatment was quite varied. However, the routine usually included handwashing, anal care, tight diapers, and restraint of hands if necessary. Drugs used included bismuth subcarbonate, oleoresin of aspidium, hexylresorcinol, quassia infusions, mercury ointment, and gentian violet. Of the eleven children treated only five had gentian violet, and of these only one had an adequate course of therapy. Three patients were followed after therapy.

The preferred treatment for pinworms is oral administration of enteric coated gentian violet[6]

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TABLE 2

Parasite	No. of Cases	Age	Pos. Hist.	Suspected	Stools (one)	Stools (more)	Treatment (any)	Treatment (best)	Follow-Up
Enterobius Vermicularis	23	1-34	8	8	8 (6 pos.)	5	11	5 (1)	3
" " of intestine	13	1-15	8	7	8 (6 pos.)	5	11	5 (1)	3
" " of appendix	10	9-34	0	1	0	0	0	0	0
Taenia Saginata	12	19-52	11	10	9	3	12	12	4
Taenia Solium	1	19	1	1		1	1	1	0
Taenia Echinococcus	1	32	Italy	0	0	0	0	0	0
Ascaris Lumbricoides	7	2½-15	2	2	5	4	6	3	1
Trichinella Spiralis	4	22-64	0 (3 typical hist. of di.)	3	3	2	Symptomatic		2
Endameba Histolytica	3	20-61	1	2		3	3	2	3
Giardia Lamblia	1	19	0	1	1		0	0	0
Totals	52	1-64	23	27	26	18	33	23	11
Percentages			44.2	51.9	50	34.6	63.5	44.2	21.2

in dosage of 0.01 gram per year of age, three times a day for eight days, a seven day rest and then a repeat course. For adults the dosage is one grain three times a day. Persistent nausea and vomiting, severe epigastric pain, or a purple color to the urine are signals for stopping the drug. In case of intolerance to gentian violet hexylresorcinol by mouth as recommended for ascariasis together with retention enemas of "S. T. 37" undiluted may be used. Pregnancy and nephritis are contraindications to gentian violet therapy.

APPENDICEAL ENTEROBIASIS

Appendiceal enterobiasis was diagnosed microscopically on ten appendices removed during the five year period. This represents an approximate incidence of two per cent of the cases of uncomplicated acute appendicitis operated at Cleveland City Hospital during that time. Corresponding figures in the literature range from 4.76 per cent reported by Rector[4] to 30 per cent reported by Schwarz and Straub.[5] Age of occurrence was naturally that of appendicitis,—ranging from nine to 34 years with the majority being in their teens or early twenties. There were nine females with only one male, and all of the children were white. The diagnosis was suspected in one case only. None of the patients was treated or subsequently investigated for worm infestation.

There is considerable controversy as to whether pinworms actually cause appendicitis or not. Schwarz and Straub[5] have described what they term a typical lesion—a half-moon shaped impression with atrophy and necrosis of epithelium, erosion and necrosis of the mucosa, and an inflammatory exudate made up of fibrin, leucocytes, and mucus. These lesions were found in twenty-two of thirty-six appendices which contained pinworms. While this is suggestive, there is a large weight of evidence[4] against any real etiological relationship. Nevertheless, there is little doubt that the mechanical presence of worms in the appendix may produce symptoms which are differentiated from acute appendicitis with great difficulty.

TAENIA

Taenia infestation was diagnosed fourteen times during the period, twelve of these being T. saginata and one each T. solium and T. echinococcus. The cases of beef tapeworm had a somewhat peculiar distribution in that there were seven in 1939, four in 1940, and two in 1941 (one a re-admission). None was diagnosed in 1942, 1943, or 1944. A positive history was obtained in eleven of the cases—most of the patients complaining of passing proglottids. The diagnosis was recorded as suspected in ten, and the drug of choice was administered in all twelve. However, the scolex was recovered in only one instance and only three patients had subsequent repeated stool examinations. Altogether four patients had some sort of post-treatment follow-up.

DRUG OF CHOICE

The drug of choice for all taenia infestations is oleoresin of male fern or aspidium. After a purge the night before with 1/2 to one ounce of sodium sulfate the dosage of 45 to 60 minims is given in three equal parts at half-hour intervals on an empty stomach. Two hours after the final dose a second purge is given and all stools saved and searched for the scolex.

An alternative and slightly more efficient method is transduodenal intubation of a mixture of four cc. of aspidium and thirty cc. each of mucilage of acacia and saturated sodium sulfate solution. Post treatment purgation is not necessary. Aspidium is a toxic drug and should be used with care. Never more than 60 minims

should be given, and hospitalization is preferable if at all possible. Pregnancy or nephritis are contraindictions to administration of the drug. Sodium sulfate is the preferred cathartic because of its tendency to dissolve mucous away from the head of the parasite.

CASE WITH PORK TAPEWORM

The one patient with T. solium (pork tapeworm) infestation was a rather interesting one. She was a 19 year old white female who had noticed tingling of the hands and feet for two weeks, when she suddenly collapsed at work. She was taken to a hospital where she developed marked respiratory difficulty. She was then brought to the contagious division of Cleveland City Hospital, where she was found to have a tetraplegia in addition to a respiratory embarrassment of such degree that it was necessary for her to be placed in a respirator. A provisional diagnosis of infectious neuronitis was made and she was given supportive therapy.

The history obtained from the family indicated that she had been passing proglottids for a period of two years. Repeated stool examinations revealed ova and proglottids which had the typical nine segment uterus of T. solium.[6] Final diagnosis was T. solium infestation with cysticercosis of the brain.

Under a regime of persistent physiotherapy she showed marked improvement and walked out of the hospital. She was subsequently readmitted for a course of aspidium. Her stools were also positive for ova of Trichocephalus trichiuris.

The diagnois of taenia echinococcus was an incidental one made at autopsy when a single calcified echinococcus cyst was found in the liver of a 32 year old Italian male who died of sub-acute bacterial endocarditis.

ASCARIS

Ascaris infestation was diagnosed seven times during the period. Age range was from 2½ to 15 years. There were five females and two males with six whites and one negro. History of passage of large round worms was obtained in two cases. The infestations were for the most part mild and with few symptoms. Lethargy, nausea, vomiting, headaches, irritability, and failure to gain weight were noted. Single stool examinations were done in five cases, repeated ones in four. Six of the seven cases were treated, three with hexylresorcinol, the others with santonin or oil of chenopodium. Only one of the cases was followed after treatment.

The treatment of choice in single infestations is Caprokol[6] (hexylresorcinol crystoids) 0.1 or 0.2 gm. in dosage of 0.6 gm. for children up to five years, 0.8 gm. for those six to ten years, and 1.0 for adults. Pre and post treatment purgation is helpful but not essential. The patients should be cautioned not to chew the crystoids. In cases of infestation with both ascaris and hookworm treatment is 0.3 cc. of oil of chenopodium, with 2.7 cc. of tetrachlorethylene. Purgation is essential.

TRICHINOSIS

Four cases of trichinosis were diagnosed during the period. In three of the cases a typical history—ingestion of raw pork followed by acute gastro-enteritis with later muscle pains—was obtained. Edema of the eyes and face, urticaria, and other allergic manifestations were present in one instance. Diagnosis was established by skin tests and muscle biopsy. Stool specimens were examined on three patients. Eosinophilia was as usual a prominent finding, maximum counts of 15 per cent to 52 per cent being recorded in the four cases. Treatment in each case was symptomatic only.

AMBIASIS

A diagnosis of ambiasis was made three times —all in the period 1943 and 1944. Positive history was obtained in one case and the diagnosis was suspected in two. Repeated stool examinations were made in each instance and all cases are being followed. Clinical manifestations were interesting and show the variety of symptoms amebiasis may present. One of the cases was a 20 year old asthenic white female admitted June 29, 1943, with complaints of increasing weakness, malaise, dull headaches, and low backaches for eight months preceding admission. White blood count was 11,900 with 19 per cent eosinophiles. Impressions included neurasthenia, trichinosis "G. I. parasites," and periarteritis nodosa. On July 17, 1943, the first stool examination was made and revealed cysts of Endameba histolytica, Endameba coli, and Iodabema bütschlil in addition to ova of Necator americanus (hookworm) and Trichocephalus trichiuris.

Another case was that of a 61 year old nervous white male who was admitted November 10, 1943, with a chief complaint of diarrhea. He had been troubled with "mucus colitis" since 1936 and had had numerous proctoscopic and X-ray examinations. On admission he was passing fifteen to twenty bloody stools per day. Proctoscopy revealed numerous ulcers of the rectosigmoid from which both motile and cyst forms of E. histolytica were obtained.

Since this study was originally undertaken two additional case of amebiasis have been diagnosed. One was a colored male admitted on February 7, 1944, with a complaint of intermittent bloody diarrhea for the past seven years. Before admission he had become so weak that it was necessary for him to quit work. Proctoscopy revealed one small eroded ulcer of the sigmoid but no

parasites could be found. Repeated stool examinations were negative. On February 19, 1944, he passed several grossly bloody stools which were swarming with motile forms of E. Histolytica.

The other case was that of a nurse who following a supposed episode of "food poisoning" had persistent diarrhea for three weeks, but an absence of blood. Stool examination was positive for both cysts and motile forms of E. Histolytica.

Four of our five cases were treated with Diodoquin[7] which has recently come to the forefront as the drug of choice. It is dispensed in tablets of 3.2 grains each of which three are given three times a day for 20 days. In severe dysentery as many as four tablets three times a day may be given. The drug itself produces no troublesome diarrhea and no toxic manifestations have yet been reported. The other patient was treated with carbarsone. None of these patients showed evidence of hepatitis or liver abscess which is stated to occur in about 5 per cent of cases.[8] Emetine hydrochloride parenterally in dosage of one grain a day for not more than ten days is used in cases of liver involvement, severe prostrating diarrhea, or "ameboma"—an intestinal mass which occurs rarely in amebic infestations.

GIARDIA LAMBLIA

A single diagnosis of Giardia lamblia was made. The patient was a 19 year old white male from Tennessee. He gave a typical history of peptic ulcer pain, but when gastro-intestinal films were made a small intestinal deficiency pattern such as is found in hookworm disease[9] was revealed. Stool examinations revealed many cysts of Giardia lamblia. Unfortunately we were unable to procure atabrine so he was discharged to the army. Treatment of choice in Giardiasis is atabrine[6,10,11] in dosage of 1½ grains three times a day for five days—the same as in malaria.

Ova of Trichocephalus trichiuris were incidental findings in the stool of two patients and those of Necator americanus in one.

DISCUSSION

There seems to be little doubt that in Cleveland City Hospital the diagnosis of intestinal parasitism is considered last if at all—and thought of very lightly as far as mangement is concerned. That a similar situation exists in many hospitals in this part of the country is quite likely.

The relative number of cases of intestinal parasitism (.08 per cent of admissions) is unaccountably small, but may be partly explained by the few stool analyses run in the hospital. Not only are routine stools neglected, but in many cases of gastro-intestinal disturbances stools are either not gotten or are thought of only as a last resort.

The absence of a diagnosis of amebiasis prior to 1943 and the long histories of two of the cases are evidence in point. The relatively low incidence of pinworm manifestation may be explained by the lack of examination by anal swab and in the case of appendiceal infestation by the fact that the specimens are opened in the operating room and much of the luminal contents lost before they are sent to the pathological laboratory.

TECHNIQUE

The zinc sulfate floatation technique[10] of stool concentration is a quite satisfactory and simple method for detection of cysts and ova in routine stool examinations where trophozoites are not expected to be found. This technique is as follows:

1. A fecal suspension is prepared by comminuting about 10 parts of tapwater with one part of the stool specimen.

2. Approximately 10 cc. of the suspension are strained through one layer of wet cheesecloth in a small funnel into a Wassermann tube (13 x 100 mm. = 10 cc.).

3. The preparation in the tube is centrifugalized for 60 seconds at about 2,600 RPM. The supernatant fluid is poured off, about 2 cc. of water are added, the sediment is broken up by shaking or tapping, and additional water is added to fill the tube.

4. Repeat "3" until the supernatant fluid is clear (usually 3 or 4 times).

5. The last supernatant fluid is poured off, about 2 cc. of zinc sulphate ($ZnSO_4$ U.S.P. granular solution of specific gravity 1.180 (33.2 per cent solution) are added, the sediment is broken up and enough zinc solution added to fill the tube to about one fourth of an inch of the rim.

6. The tube is centrifugalized for 60 seconds at top speed.

7. Several loopfuls of diagnostic material floating in the surface film are removed by means of a wire loop onto a clean slide, one drop of D'Antoni's iodine stain is added and the

TABLE 3

Parasite	Position	Diagnosis	Treatment
Enterobius Vermicularis	Colon Appendix	Anal Swab	Gentian Violet
Trichocephalus Trichiuris	Cecum Appendix	Stool	Leche de Higueron
Ascaris Lumbricoides	Small Intestine	Stool	Caprokol
Necator Americanus	Small Intestine	Stool (X-ray)	Tetra-Chlore-thyleme
Strangyloides Stercorales	Duodenum Jejunum	Stool	Gentian Violet
Taenia	Small Intestine	Stool	Aspidium
E. Histolytica	Colon	Stool	Diodoquin Emetine
Giardia Lamblia	Duodenum Jejunum	Stool Billary Drainage	Atabrine

preparation agitated manually to insure a uniform mixture.

8. The preparation is mounted with a coverglass and is now ready for examination.

Table 3 shows location, diagnostic method, and treatment of choice of the more common parasites.

SUMMARY

In summary we see that from January 1, 1939, to February 1, 1944, there were diagnosed 52 cases of intestinal parasites in Cleveland City Hospital. There were 34 females and 50 white persons in the group. A positive history of infestation was obtained in 44.2 per cent while the diagnosis was suspected in 51.9 per cent. Single stool examinations were done in 50 per cent of the cases and repeated stools in 34.6 per cent; 63.5 per cent of the cases were treated, 44.2 per cent with the optimal drug. Only 21.2 per cent of the cases were followed after treatment.

It is suggested that parasitic infestation is not uncommon in Cleveland and that more frequent stool analysis will explain the symptoms of many patients with unaccountable diarrhea or vague gastro-intestinal complaints. More adequate follow-up of discovered cases also seems indicated.

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Our health agencies have already hoisted their flags over large fields, some of which (possibly most of which) they occupy so thinly as to be ineffective. To make good our plans for the prevention of disease and the postponement of death, we must keep the preventive aspect clearly in mind. Until we have gotten much farther along toward the complete control of tuberculosis, syphilis, gonorrhea, and other preventable diseases, we cannot, as health authorities, seek or take on the tremendous task of securing good medical care for everybody. That may come unsought, in some degree, in time, probably piecemeal, but we are certainly not ready for it now. To spread out over still wider areas, would mean being even less effective than we are now in many of our preventive efforts.—Homer Folks, Amer. Jour. Pub. Health, Feb., 1944.

KEEPING UP WITH MEDICINE

IN all patients with severe epigastric or upper abdominal pain, acute pancreatitis should be included as a diagnostic possibility. Diagnosis by clinical methods alone is usually impossible, but should be confirmed during the acute phase of the illness by a serum amylase test. This test is practically specific for acute pancreatitis and seldom gives positive results which turn out to be false.

* * *

IT has been estimated that there are about as many cases of spontaneous hypolycemia as there are true cases of diabetes mellitus. If this estimate is accepted, it means that there are more than one-half of million persons suffering with spontaneous hypoglycemia and all too few of them recognized. Most of them slip through our hands as possible epilepsy, psychoneurosis, neurasthenia, menopausal neurosis and other wrong diagnoses.

* * *

IT is becoming more and more apparent that the safe amount of benzol to have in the air is absolutely none. Upon exposure to a large amount we see a progression from granulocytopenia, thrombopenia and anemia, ending up in a pancytopenia, or aspastic anemia. If there are minimal amounts of benzol over a long period of time one finds the opposite time type of blood picture: polycythemia, leukemia, and finally myeloid metaplasia.

* * *

ANY silver compound is capable of producing argyria when used for a sufficiently long time by any other route than the intact skin.

* * *

AFTER carotene is absorbed from the intestinal tract, it is converted into vitamin A. The conditions which commonly interfere with the hepatic metabolism of carotene are hypothyroidism, advanced liver disease, and diabetes mellitus. In these conditions it may be deposited in the skin and produce a diffuse yellow pigmentation. Hence carotenemia may well be and often is confused with biliary jaundice.

* * *

IN chronic barbiturate poisoning the condition may escape understanding. Such poisoning may beget euphoria, a state of feeling altogether out of keeping with the patient's apparently poor health. But the chronic poisoning is more likely to exhibit itself in diminished mental alertness, in lessened interest, in more difficulty in understanding, in poor attention, in disturbance of association, and in impairment of the memory. In this connection it is well to remember that one per cent of all admissions to all mental hospitals in this country are due to drug addiction and bromides and barbiturates are the two drugs usually involved.

Neurotic Reactions In Soldiers

JOSEPH FETTERMAN, M.D.

A NEUROSIS is a form of illness associated with internal problems of the personality, representing a failure of adaptation to circumstances (Snowden[1]). Its origin is the psyche, it is geared to inner mechanisms, yet its expression is strongly influenced by external forces, appearing in different regions and with fluctuating intensity. A neurosis is sometimes rooted in constitutional soil but is cultivated and grows through life's experiences.

The example of neurotic illness among parents, the insecurity of an unhappy childhood, alternating parental affection and hostility, conflicts of the child between impulse and inhibition never resolved but repressed, such impacts and experiences fashion a pattern of personality in which fear is strong and sickness becomes a compromise solution for internal and external problems[2].

The psychoneurotic* thus grows up somewhat insecure and timid, concerned with himself and his organs, overly fearful, the fear expressing itself by motor signs or visceral betrayal, inclined to introspection and anxiety. There is an undue amount of fear and doubt in ordinary life's situations, a dependence upon parents, a concern about self—all of which is transformed into disturbed visceral action and manifested by a great variety of symptoms.

In its severe form a neurosis may be chronic and cause disabling symptoms. Yet normal persons, faced with threats or weakened by a series of unfavorable situations develop symptoms, simliar in form but usually of a temporary nature.

TYPES OF NEUROSES

Each patient presents individual features but it is feasible to group the symptoms under several headings. The well-known classification of Freud, including the neurasthenic, hysterical, obsessional and anxiety forms is based upon delayed development of the libido during infancy. A classification according to symptoms emphasizes the predominant manifestations—anxiety states, psychosomatic features, conversion hysteria, etc. My experience substantiates that of Parsons[3] who reported that anxiety states with depression as the predominant type of neurosis among soldiers. Hadfield[4] likewise stressed the great proportion of anxiety states in this group. The type of symptoms is determined by the combination of war experience and the personality of the patient.

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*The terms "neurosis" and "psychoneurosis" are used interchangeably.

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Essentially, neuroses of war resemble those of peace. This applies particularly to the nervous states developed soon after induction and long before exposure to exhausting and alarming experiences. The factors of predisposition and constitution are marked. Fairbairn[5] associates such neuroses with abnormally persistent childhood dependence and the marked separation-anxiety which results when the person is deprived of such base of support. Thus the development of marked anxiety from homesickness is indicative of such abnormal attachment. It seems, says Fairbairn that the capacity to endure danger varies to the degree to which an individual has outgrown infantile dependence. The neuroses that appear early in the trainee are similar to and expressed by symptoms akin to those in pre-military life.

Yet the neuroses of combat are somewhat different as to immediate cause and symptoms. For example, Smith[6] reported the reactions of certain marines, essentially a healthy, toughened group of men who fought the Japs on Guadalcanal. They endured the accumulated and overwhelming hardships of heat, rain, insects, fever, poor rations, insufficient sleep plus the incessant threat from bombs and bullets. These marines lost weight, became jumpy and then developed a syndrome characterized by headaches, sensitivity to sound, tremors, periods of amnesia, and hysterical paralysis. The symptoms were more acute, more dramatic, the external factors more obvious than in everyday neuroses. To account for this apparent difference let us consider the factors which influence types of symptoms.

SYMPTOM DETERMINATION IN NEUROSIS

Many factors go into the type of symptomatology of neuroses. Recently Alexander[7] explained hysterical conversion symptoms as a translation of a psychological process into a bodily symptom, the symptom being a symbolic substitute for an

unbearable emotion. The vegetative symptoms occurring in the autonomic system are not the substitutes but the accompaniments of emotional states. Alexander believes there is a specific relationship between emotional factors and vegetative expression, stating that patients with gastric neuroses suffer from a constant need to be loved, a persistent wish to be fed.

In a previous study on neuroses which developed in industrial cases featured by back disabilities of psychic origin I[8] stressed the importance of local organic pathology as the core of neurotic symptoms. Pain and stiffness resulting from trauma tend to direct attention, and to draw anxiety and preoccupation toward the affected region.

As one observes neurotic symptoms in soldiers, it is apparent that there are many indivual factors that guide or determine the type of neurotic symptoms. Some of these are:

1. **A continuation of unpleasant physiologic reactions.** Crashing bombs, whistling bullets, lurking danger causes fear. Fear has its physical counterparts: frozen muscles, speechlessness, faintness, and marked trembling. The trembling begun as a physiological reaction continues on and on. Thus many of the soldiers who manifested nervous reactions following the Sicilian invasion were called "jitterers" because of the marked tremors and violent shaking. Thus the form of the neurosis was but the persistence of the initial physiological reaction.

2. **Trauma: Prolongation of the symptoms caused by trauma.** A paratrooper makes a faulty landing and strikes his head. He develops headaches though there has been no serious intracranial injury. The occurrence of the injury becomes a critical event which decided the inner conflict between duty and "disability". The symptom of headache has continued on and on, even though this paratrooper was evacuated to the zone of the interior.

A corporal in the medical detachment had passed through several harrowing experiences, and was able to exercise self-control over his anxiety. One day he was injured by a bomb explosion, sustaining several shrapnel wounds in the thigh. The wounds healed well, without serious damage to nerves or muscle. However, he developed a marked limp and a peculiar slow gait, keeping his right knee flexed. The hysterical nature of this gait disorder was fully established when the symptom was entirely cleared up by suggestion. The pain, swelling and limitation of motion resulting from injury decided the specific development. The mechanism was a continuation of the original organic lesion, the limping prolonged by autosuggesion, prolonged also because it solved inner problems.

3. **Identification.** Frequently the symptoms represent an imitation of, a copy of the symptoms suffered by some person with whom the patient was emotionally linked. We are all familiar with patients who develop hysterical hemiplegias similar to father's stroke. Imitation of fellow patients, adopting the type of symptoms prevailing at the time may explain in the forms of expression of the neurosis. The occurrence of a dramatic exhibition such as a convulsion may be followed by other like "attacks". Identification means contagion in ideas.

4. **Effectiveness of the symptoms in service of the ego.** In civilian practice there were many cases of impotence, in military experience there are few cases with such complaints but an unusual number of postural and gait disabilities of functional origin. Such symptoms become an embodiment of an idea, expressing more eloquently than words "I cannot march, I cannot shoot, I am no longer useful as a soldier." It is remarkable that once the neuro-muscular disability has developed, the patient may appear otherwise content and state verbally "I'd like to serve my country as a fighting man—if only my paralysis cleared up." Such symptoms do not express anxiety but an escape from unbearable fear (Goldstein[9]).

As was expressed by Alexander, certain pent up emotions may be accompanied by visceral manifestation (hypertension) or represent a conversion of inner repressed material. At times viscera betray fear even though the patient consciously wishes to conceal it. Sgt. —— was a waist gunner in a bomber, deeply attached to the other members of the crew and very fond of his ship. After he had gone through many missions successfully he was injured slightly. So eager was he to continue with his buddies that he asked quickly to resume his place as soon as the wound healed. On the next mission he developed gastrointestinal symptoms and the distress grew worse as the bomber was struck by flak and its wing damaged by fighter bullets. Again he insisted on being part of the crew; consciously he wanted to continue but there was a visceral betrayal of inner anxiety by anorexia and nausea. His gastrointestinal symptoms led to his being grounded.

5. **Vulnerability of certain regions.** Clinical experience shows that certain areas or functions are more sensitive to upset than others. Fatigue causes backache in one person, insomnia in another, and faintness in a third. The Achilles Heel is in a different site or function in different individuals.

FACTORS CAUSING NEUROSIS IN SOLDIERS

The majority of the constitutional neuroses are or should be excluded at the Induction Boards. Rowntree[10] summarized the effectiveness of screening with the statement that some 20 men were rejected for every soldier discharged

for neuropsychiatric difficulties. But among the soldiers discharged between July, 1941, and January, 1943, 30 percent were discharged for mental diseases or personality disorders. Hence we should concern ourselves with the causes of neuroses in War.

We may begin with the statement that rarely does one factor alone explain the development of a neurosis. Life is too complex, and all reactions represent an interplay of man and his milieu, of patterns inherited and developed, of forces that threaten and demoralize opposed by defense mechanisms, of individual desire and group influence. The final symptomatology then is the outcome of this interplay. Let us consider the factors under the heading of (1) the individual, (2) the war situation, (3) morale factors.

THE INDIVIDUAL

The tendency to neurosis varies remarkably. The Lancet[11] calls attention to the difference in constitution as explaining why only some of the British solders developed disabling neurotic symptoms among the many who went through the retreat of Dunkirk. This tendency means a greater spread of emotions through vegetative and motor centers; a lesser capacity for control; a tendency towards weakness, a tenacity of the fearful. This may appear in the form of anxiety about one's self, physical symptoms, or disturbed sleep with terror dreams of battle. Some patients dwell excessively upon the horrible experience, others exclude it from memory when they develop amnesia. But the neurotic seems unable to push the experiences of battle out of the foreground of the consciousness, seems unable to cope with the effects of fear. Such a personality sometimes clings to the illness, as though choosing it (Stephen—"The Wish to Fall Ill"[12]).

THE WAR SITUATION

The strain and terror of warfare are terriffic. Sargent and Slater[13] list the accumulation of mental and physical strain—bodily danger, continuous physical exertion, loss of sleep, irregular and inadequate meals, bombardment, the sight of panic and death, and the sense of frustration at being unable to strike back. Mira[14] adds the important factor of fear and doubt, fear of unknown danger, fear of sudden attack, doubt about one's leaders and one's cause.

To face the problems squarely one can not start with the most serious war situations. Let us consider the factors as they develop. At first, the trainee is disturbed by having to give up his accustomed routine, the support of his usual hobbies, his vocation, his social life, his independence.

Army training and discipline subject him to regimentation, to control, to unaccustomed tasks. Fortunately, for most soldiers army life is a new adventure to be accepted and even enjoyed. Some soldiers feel they have been expected to make an unfair sacrifice, they are oppressed by a longing for home and for those "fences" they have built around their private lives. Then comes the hardship of training the sternness of the sergeant, a disappointing assignment.

After the soldier passes through his basic training he is sent to a staging area to join an outfit destined for overseas. Rumors fly around, talk of submarine danger, anxiety about the future. Later comes the theatre of combat and the approach to and finally the actual fighting. Here the situation is one of alternating monotony and exhausting marches, shooting and being shot at, deprivations of water and even of food, exploding bombs, injury and death.

War exposes the soldier to physical exhaustion, the heat of the tropics or the cold of the Aleutians, food from cans, insects, fever, marching, fighting. Many soldiers in the tropics lost considerable weight as a result of these deprivations and stress. Equally important are the horrors of men being maimed and killed, painfully felt when one's "buddy" is the victim. And added to these exposures are actual disease and injury—diarrheas and fevers and concussions and wounds. These are the terrors and strains that confront the modern soldier.

Obviously the type of exposure is different in combat crews than in paratroops; different in medical regiments than in the infantry. The combat crews face not physical exhaustion—but waiting, hours, hours, hours of waiting until the target is reached, thoughts of pals in the squadron who failed to return—hazards of altitude and cold and oceans, dangerous flak, menacing fighters. The paratrooper faces injury from the fall and the hazards after a successful landing. Each paratrooper "sweats it out" before the jump. The infantry endure physical privations and exhaustion.

Such stress obviously produces uncomfortable sensations, pain, and weakness, and uneasiness. Every soldier experiences fear at the moment of attack. War surrounds soldiers with the precipitating factors for nervous illness.

MORALE

The evaluation of the individual and of the horrors of war leaves out an item of tremendous import—the impact of the group—morale. Rousseau once remarked that man is born free but is everywhere in chains. Man is not born free—he is born helpless, dependent, attached—linked to his fellow men for his own safety and survival. What his fellow men think and do, influences his thoughts and actions. His ideas and ideals, his convictions, his loyalties, his morale is a part of the group, of the culture.

As a soldier he is asked to pay his indebted-

ness to his country with his time, his services, with his life if need be. His willingness to accept his part as a soldier, his confidence in self and country and cause are determined by what others are saying, writing, doing. Confidence in the righteousness of his cause, gives him calmness and courage. Fortitude, says Crichton-Miller[15] is influenced by suggestion and by the feeling of a common cause and transcending purpose. Confidence in cause, willingness to endure and to make sacrifices—in other words—morale is decisive in the problem of neuroses.

Rees[16] states that morale and neuroses are in reverse ratio. Though mankind is much the same physiologically and psychologically and the accumulated hardships of war on the Russian Front have been tremendous, the incidence of neuroses is surprisingly low among the Russians. The low incidence of neuroses reflects high morale. Broder[17] accounts for this high morale among the Russians as the product of the intense preparation of the people psychologically and materially to fight a war of death in defense of their country.

The soldier who feels unjustly treated by his leaders, who develops a resentment against unfair advantages enjoyed by others or who protests inwardly against the heavy burden placed upon him, such a soldier develops a state of self-pity, unhappiness and bitterness. These unpleasant emotional reactions make him prone to cling to physical symptoms which have developed from fear, fatigue, or illness. The symptoms, tenaciously held become a disability which serves as an acceptable pass to safety and to the comforts of home. The "neurosis-door" to an honorable discharge is opened by physiological symptoms and kept open by mental attitude influenced by morale standards.

TREATMENT OF WAR NEUROSES

To meet this problem, to reduce the number of neurotic disabilities we much approach the problem from several angles. We must consider the man; we must approach morale, and face the problems of the military situation.

(a) **Selection.** The constitutional neurotic, who lives insecurely at best, who maintains precarious security by precautions, medication and careful living is too prone to develop illness when exposed to hardships of soldiering. He should be excluded from the armed forces. To prevent neuroses at the front line we must exclude them at the front door—the Induction Station.

(b) **Psychological preparation along with military training.** Our training for warfare should have begun long ago, the training of our youth towards physical toughness and psychological preparedness. Since our youth has been raised in an era of peace, softness, security, and self-concern the transformation into a fighting man is no mean task.

Now we must start at the draft board, continue through the induction board and at the Reception Center. The inductee and trainee must be made to feel that his is an opportunity to serve his country, that it is an honor thus to be selected. During the Replacement Training period he should be given health talks such as those introduced by Major Cohen.[18] The new soldier is thus prepared, immunized against the earlier unpleasantness of his new career.

Psychological training requires emphasis upon confidence in cause and hatred of the Enemy (Porter[19]). Such training should not only prepare the soldier for actual hardships and hazards of combat physically but imbue him with a will to victory. He should be instructed by lectures, movies, music, by examples of American heroism and sacrifice as well as by scenes depicting the cunning, the cruelty, and the bestiality of our enemies. We must teach our soldiers the prudence of defending our land, our liberty, our families by attacking and not waiting to be attacked.

Major Schreiber[20] stated that a high morale sense, based upon a will to defend democracy will reduce neuroses. The soldier who knows and feels that there is no room in the world for Hitler, Tojo, and himself, who believes that he is fighting for his family and for liberty, will readily accept the hardships of soldiering. A high sense of duty means a low per cent of nervous disease.

(c) **Preventive treatment during combat conditions.** The stresses of warfare are not readily modifiable, yet whatever can be done by way of supplying sufficient salt and water in the tropics, rest for men exhausted, leaves for pilots showing premonitory evidence of fatigue in helpful. Good physical training, active diversion, and again lectures, talks, examples to build confidence and morale, must be continued. Work removes worry in war as in peace.

(d) **Treatment of acute neurotic states occurring in combat.** Despite careful screening at Induction Centers and the sifting out of emotionally inadequate soldiers during the phase of basic training there will be a considerable number of neurotic reactions upon exposure to combat. The conditions of warfare are such as to initiate nervous states even in some who have been previously normal. Day after day of long marches through mud and rain, nights sleepless because of air raids, shrapnel from artillery fire, the terrorizing shriek of stuka bombers, the sight of the wounded and particularly the horrible feeling when a pal is killed, these and many other experiences confront the soldier.

And there is a point of endurance where even the normal soldier gives way. This point is not merely determined by the degree of stress but

rather by the relation between the qualities of the man and the stress. The qualities include physical stamina, resiliency in the physical and mental sense, skill and confidence. But when the point of tolerance is reached—especially when fear becomes overwhelming or complete exhaustion, an illness or an injury has occurred, then symptoms develop. These appear in various forms: marked tremors with jumpiness at the least sound, sleeplessness, fear, severe autonomic upset exhibited by rapid pulse, loss of appetite, intestinal symptoms, muscular weakness or paralysis; episodes of amnesia and confusion, or even marked stupor.

There are many "exit gates" from scenes of horror and fear. The value of such nervous symptoms in providing escape with honor may explain the tendency to emphasize and prolong them.

In some instances these symptoms appear in soldiers who are eager to fight on. Yet they are unable to control the trembling, the weakness, the terror dreams that make sleep impossible. Try as he will consciously to silence it, the voice of the viscera betrays inner fear by abdominal pain and diarrhea or through marked weakness. In other cases the symptoms are accepted or welcomed as an honorable means of escape from the horrible situation.

Treatment in the combat zone demands an early selection of those who are likely to return to duty from those more severely affected and who should, therefore, be evacuated. According to Circular Letter 176, Office of The Surgeon General, prompt treatment in the division area such as rest, reassurance and discussion may succeed in returning a mild case to duty. Heavy sedation should be initiated early, achieved best through the use of sodium amytal grains 6-9 orally or an equivalent dose of a similar rapidly acting sedative. Rest and food are prerequisites to psychotherapy.

As soon as possible psychological handling is employed. There are soldiers overwhelmed by fear, by an inner sense of guilt, by the deep impress of horror which they seem unable to shake off by will or by rest. There is a feeling of fear and resentment which must be calmed or cleared. Prolonged sleep may be needed in some instances, sleep lasting several days.

In other instances, the chance to tell his troubles, to "unload" his pent up emotions, to be relieved of a sense of guilt, such opportunity eases the inner tension. The medical officer should provide such an opportunity, listening rather than lecturing. Then by reassurance, by guidance, by firm leadership, the officer rebuilds confidence and aims to restore the refreshed soldier to combat usefulness. Sometimes leadership consists of an appeal to the loyalty of the soldier to his buddies and his outfit, or if this fails then the use of scorn may be required to help a soldier exercise self-control and return to his duty. The aim of the medical officer is restoration of the soldier to not retreat from duty.

There are those who benefit from rest and the opportunity to free themselves emotionally of harrowing experiences. The symptoms then subside. Yet if symptoms persist, especially if there are gross motor difficulties strong suggestion should be employed (Wittkover and Spillane[22]).

The normal soldier, temporarily nervous because of stress is likely to respond to such methods, especially if his morale is high. But others cling to their difficulties and must be evacuated to the rear.

(e) **Change in milieu.** There are some neurotic soldiers who will not respond to a program of physical and morale "lifting". Their symptoms persist as long as they remain in the theatre of combat or as long as recovery mean re-exposure to the frightening and exhausting dangers. They have become sensitized to the sound of planes, to the explosion of bombs, even though far away (Lt. Col. Berezin[23]). Then only a change from combat to non-combat duty or in many instances transfer to the zone of interior (safety) become necessary to provide relief.

(f) **The sub-acute and chronic neurotic states.** In some instances even a transfer to the continental United States fails to reduce the tremors, does not clear up the paralyses, does not effect a removal of complaints. The tenacity of the symptoms then can be explained as due to the ever-present strain of remaining in uniform or to a constitutional neurotic makeup. The program of therapy must strive to rehabilitate the individual first as a soldier and if this fails, then as a useful civilian. To attain these goals psychotherapy aided by all the methods of exercise, medication, instruction, and occupational activity are needed.

Blair[24] pointed out the efficacy of group treatment of soldiers. My experience confirms his report as to the time-saving efficacy and the beneficial value of the group effect. The therapist may call upon the force of the group, the contagious influence of ideas, the pressure of a sector of public opinion as well as his own leadership. Frequently, the influence of a physician must be supplemented by multiple aids as has been so successfully accomplished at Mill Hill, England.[25]

When it is not feasible to convert the patient into a useful soldier we must try to rehabilitate him towards a useful civilian. A patient who will thus be discharged should get occupational training, vocational guidance and later helped towards a job (Fetterman[26]). A pay envelope is an inducement towards recovery, a pension is an incentive to a prolongation of nervous symptoms.

We must restrain our sympathy to keep from subsidizing neuroses.

COMMENT AND CONCLUSION

Though mankind as a whole possesses the resiliency to rebound from reverses and the plasticity to adapt to hardships yet there are some who react to difficulties with nervous symptoms so marked as to be disabling for no adequate reason. They are the constitutional neurotics. Others develop like symptoms when exposed to additional hardships and hazards. Finally any normal person can develop similar symptoms temporarily under the overwhelming stress of exhaustion, terror, and injury. Warfare surrounds man with such threats.

The type of nervous symptoms will be determined by (1) the personality, (2) injury, (3) other local pathology, (4) identification or imitation of others, (5) as a continuation of symptoms started by fear-producing mechanisms.

Though every soldier is exposed, only some develop nervous illness. The soldier's personality and the morale attitude influenced by the group will determine the occurrence and persistence of disabling symptoms. Soldiers with normal resiliency, not too dependent, with a high morale will take training in their strides, accept assignments cheerfully or with healthy "discontent", will endure the hardships of combat. Should they develop an illness or sustain an injury, recovery will not be too long delayed. A sense of duty and the will to win push fear and preoccupation with symptoms into the background. Should temporary nervous reactions occur as a result of intense exposure, then prompt treatment of exhaustion and anxiety will bring about recovery.

In our major purpose of winning the war we must utilitize our manpower efficiently. Neuroses are a weakening waste of manpower. Therefore we must make careful selection, employ prompt treatment so as to salvage soldiers and civilians. If warfare threatens man's security, morale is a shield against this threat. And, finally, between the overwhelming stimuli and the symptoms resulting, it is the personality of the man, his mental attitude that determines the presence or absence of disability. Personality is a prism between defect and disability. The personality may be guided by psychiatrist and by public opinion.

The psychiatrist through services of selection, mental hygiene at replacement training centers, prompt treatment of the physical and mental symptoms in the combat areas, and finally all forms of therapy in the zone of interior contributes toward returning the soldier to duty or, if this fails reconverting him into a useful civilian. Yet the impact of society also exerts an influence. Prevailing public opinion, permeating into the thoughts of every soldier, influences his attitude toward recovery. Thus many factors determine the mental health status of the fighting man. To appreciate the nervous reactions of soldiers we must view the over-all picture of the man, his morale, and the milieu.

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It is often said that the death rate from tuberculosis is a delicate index of social progress. If this is so, one of the most striking features in the history of public health is the steady decline of both pulmonary and non-pulmonary tuberculosis during the past two generations. There are many factors responsible for this decline, including a higher standard of living, better housing and better education, but these are only contributory. It must never be forgotten that tuberculosis is first and last an infectious disease. Anything that increases the risk of infection will cause a rise in the incidence of the disease, and anything that diminishes that risk will result in a rapid improvement in the figures. —James Mackintosh, M. D., New Jersey Pub. Health News, Dec., 1943.

Severe Toxicity and Death Caused by Sulfathiazole
A Case Report and Necropsy Findings

C. F. VILTER, M.D., and I. M. SCHEINKER, M.D.*

WIDESPREAD and increasing use of the sulfonamide compounds in the past eight years has resulted in a fairly accurate knowledge of the pharmacology, toxicology, and pathologic responses of tissues to these substances. The more common manifestations of toxicity and sensitivity have been reviewed by Janeway.[1] A summary by Simon[2] of reported pathologic lesions indicates that the skin, the nervous system and most of the viscera including the cardiovascular system may show fairly specific tissue changes. It is apparent that the greatest number of deaths which have so far been attributed to the sulfonamides have been due to mechanical interference by acetyl-sulfonamide crystals in the genito-urinary tract.

In the necropsy material described by Lederer and Rosenblatt[3] it was first noted that renal parenchymal changes, independent of crystalline concretions, were probably part of a general pathologic picture capable of producing death. Similar and perhaps identical pictures have since been described in a small number of cases.[4] Although French and Weller[5] have reported a large number of instances of interstitial myocarditis due to sulfonamides, the histopathology of the other organs in these cases is not recorded. Roseman and Aring[6] and Scheinker[7] have described instances of hemorrhagic encephalopathy due to the sulfonamides and many other reports of localized lesions have appeared. It seems likely, however, that the pathologic lesions are generalized, though they may be predominant in one or more organs.

The opportunity was afforded us to study the material from a case of sulfathiazole toxicity of unusual severity, a case in which widespread pathologic lesions were discovered. The patient was not observed by us during life and the clinical material was gathered from the records of Middletown Hospital, Middletown, Ohio, and conversations with the patient's physicians.

CASE REPORT

J. S.—A 33-year-old white man presented himself to his physician on November 5, 1943, complaining of gonorrhea. Upon substantiation of the diagnosis of acute gonorrheal urethritis he was instructed to take sulfathiazole, gm. 1.0, every four hours and to use a "silver preparation" locally. After four days of adherence to this regime the urethral discharge stopped. Administration of sulathiazole was continued. On the morning of the fifth day he complained of "gas on the stomach" and "indigestion". He was told to take sodium bicarbonate with the sulfathiazole. On the evening of the fifth day he was distressed by increasingly severe pain in the epigastrium and some nausea. The treatment with sulfathiazole was discontinued. A rash appeared over his entire body and subsequent to several epistaxes he began to vomit blood-stained material. He was admitted to the Middletown Hospital early on the morning of the next day, November 11, 1943, six days after the treatment for gonorrhea was initiated.

There was no history of any previous disease of unusual nature. There was no record of any use of sulfonamides prior to the present illness.

A review of systems was not recorded. The past history was essentially negative.

A physical examination by his physician at the time of admission revealed the following pertinent physical findings: Temperature 100°, pulse 140, respirations 40. The patient was a muscular, well-nourished individual complaining of epigastric pain. A diffuse purpuric type of rash that faded on pressure covered the entire body. It was more pronounced on the back and buttocks where the lesions had become conglomerate. There was a large subconjunctival hemorrhage in the left eye and all mucous membranes were severely congested. No abnormalities were found in the lungs. The heart was apparently of normal size, rate 140, rhythm regular and no murmurs. Blood pressure was 110/70, and later 100/70. The abdomen disclosed nothing unusual except that the spleen seemed "slightly enlarged". There was no discharge from the urethra. No neurological abnormalities were noted.

Laboratory data red blood count, 4.05 million; hemoglobin, 12 grams; white blood count, 23,000; differential white count: PMN, 76 per cent and Lymph. 24 per cent; platelet count 600,000. Icterus index 6. Blood sulfathiazole, 17 mg. per cent. Urine: red; specific gravity, 1.031; albumin, trace; sugar, 0; reaction, "acid"; granular casts, 10-12 red cells and 15-20 white cells per high-powered field; many "crystals".

Course: Shortly after admission the patient became delirious and restless. He coughed frequently and expectorated bloody mucus. He took small amounts of water by mouth and complained of thirst. Emesis of clear fluid was repeated several times. Urine output was apparently adequate. The pulse continued at a rate between 140 and 150 and gradually became thready and irregular. Acrocyanosis and profuse cold perspiration appeared. Treatment was limited to sedation and intravenous glucose solution. Spinal puncture was performed on the second hospital day. The pressure was not measured, but the operator did not believe it to be increased. The cerebrospinal fluid was grossly bloody, and a cell count was not done. The patient expired during

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This is the nineteenth in a series of "Case Records Presenting Clinical Problems" selected by Richard S. Austin, M.D., professor of pathology, University of Cincinnati College of Medicine.

the procedure, 34 hours after admission to the hospital.

Necropsy was performed approximately one hour after death. There were no facilities for weighing or measuring organs. The significant findings are noted:

The skin showed considerable ecchymotic areas over the entire posterior aspect. These appeared to be post mortem changes. No rash or purpura was apparent. There was no edema of the face or ankles. There was a large hemorrhage in the left conjunctiva. The gums, palate and sclerae showed no bile staining.

The sternal marrow was normal in amount and appearance.

The pericardium contained about 75 cc. of straw-colored turbid fluid. The heart showed no enlargement, and the right ventricle was collapsed. The left ventricle was of normal contour. There were many small hemorrhages throughout the epicardium. The myocardium and endocardium were normal in appearance.

The lungs were easily removed. The pleura was normal. There was moderate congestion equally distributed throughout both upper and lower lobes but the tissue remained crepitant. Upon cutting, a moderate amount of fluid disbursed from the lung and purplish and white foam could be expressed.

The stomach was normal except for a few small, mucosal hemorrhages. The spleen seemed to be about twice normal size and showed only moderate congestion. The liver, normal as to outer appearance, cut with lessened resistance. The lobular structures were made out easily and the tissue was quite friable. The appearance suggested only moderate congestion.

The kidneys were of normal size and not swollen. The surfaces were normal and when cut, the capsules stripped easily without rolling of the edges. The cut surfaces were deep purple with fine streaking in the cortices which might represent hemorrhage. In the pelvis of each kidney there were a few ecchymotic spots, the locations of which bore no relationship to the pyramids. They lay rather close to the junction with the ureter. The urinary bladder contained about 300 cc. of turbid, amber urine. The mucosa was normal. The urethra and prostate were not dissected. Expression of the penis disclosed a moderate amount of white discharge. The adrenal glands were normal in size and on cutting, a medullary cavity gapped. The cavity was filled with a jelly-like mass of dark brown color.

The brain, viewed from the upper and lower surfaces, showed a general fullness of both hemispheres, more prominent on the right than the left. In addition there was a slight indentation of the cerebellum bilaterally. This was associated with a general engorgement of the superficial veins. The subarachnoid space at the base contained a considerable amount of blood, particularly over the pons and in the interpeduncular region extending forward into the left Sylvian fissure.

Multiple coronal sections through the brain disclosed a diffuse congestion throughout the gray and white matter with occasional scattered small perivascular hemorrhages confined chiefly to the white matter.

MICROSCOPIC

The pathologic findings, exclusive of those in the central nervous system, can be briefly summarized as follows:

Liver—The most prominent abnormality consisted of diffusely scattered numerous areas of focal necrosis as illustrated in Figure 1. These necrotic areas were characterized by fragmentation of cells, karyolysis, and karyorhexis associated with a relatively mild infiltration with polymorphonuclear cells. The necrotic foci varied considerably in distribution and were found in the center as well as the periphery of the lobule. There were very few inflammatory cells and no evidence of scarring or of repair. The architectural pattern of the preserved liver parenchyma was maintained. The perisinusoidal spaces were occasionally widened and filled with a few red blood cells or serous fluid. The Kupfer cells showed a slight degree of swelling and proliferation. The liver cells outside the necrotic foci were generally well preserved. There were in addition changes characteristic of acute passive congestion.

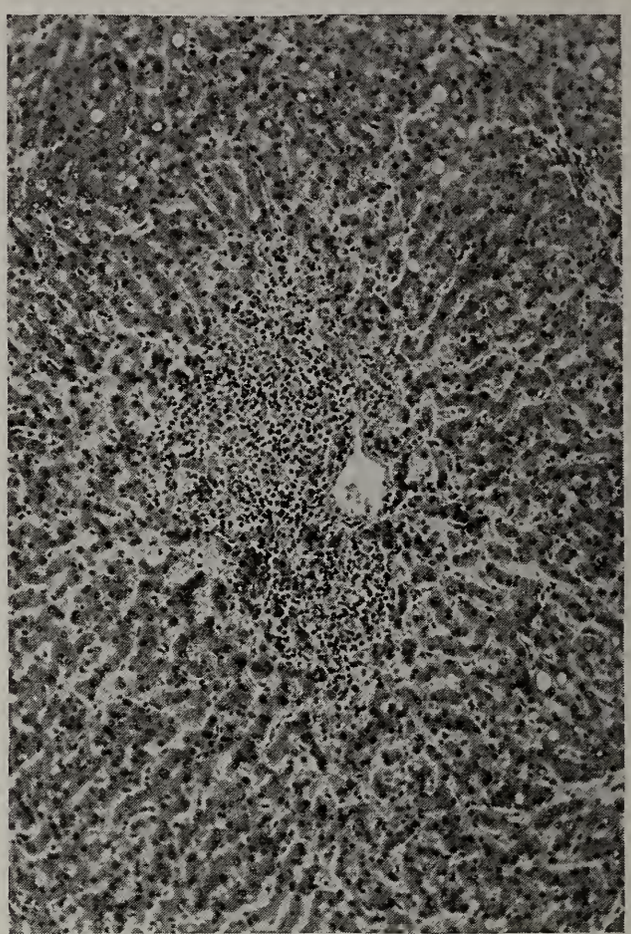


Figure 1—Liver: Focal area of necrosis characterized by fragmentation of cells; mild infiltration of polymorphonuclear cells. X125.

Kidney—The outstanding changes in the sections taken from both kidneys consisted of a dense proliferation of interstitial cells, as illustrated in Figure 2. There were also a few areas of focal necrosis similar to those found in the liver. Many of the tubules and glomeruli disclosed a marked cellularity, chiefly due to a proliferation and hypertrophy of the interstitial cells. Nothing suggestive of an acute inflammatory process was present. Rarely in the central areas of focal necrosis were to be seen a few polymorphonuclear leukocytes. The tubules, especially the proximal, convulated and the ascending limb of the loop of Henle showed a definite cloudy swelling of the epithelial cells. There were

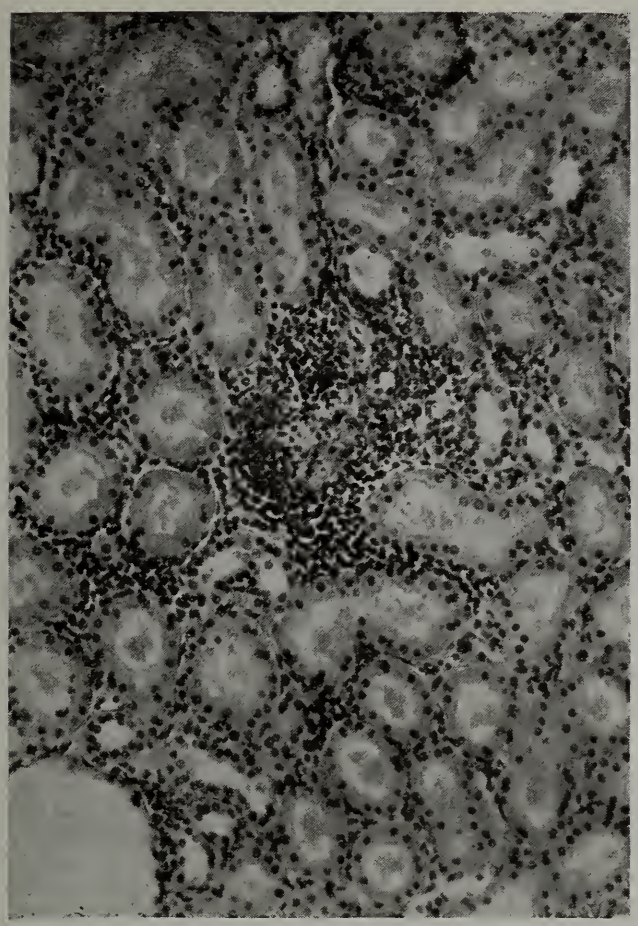


Figure 2—Kidney: Dense proliferation of interstitial cells and small area of focal necrosis. X225.

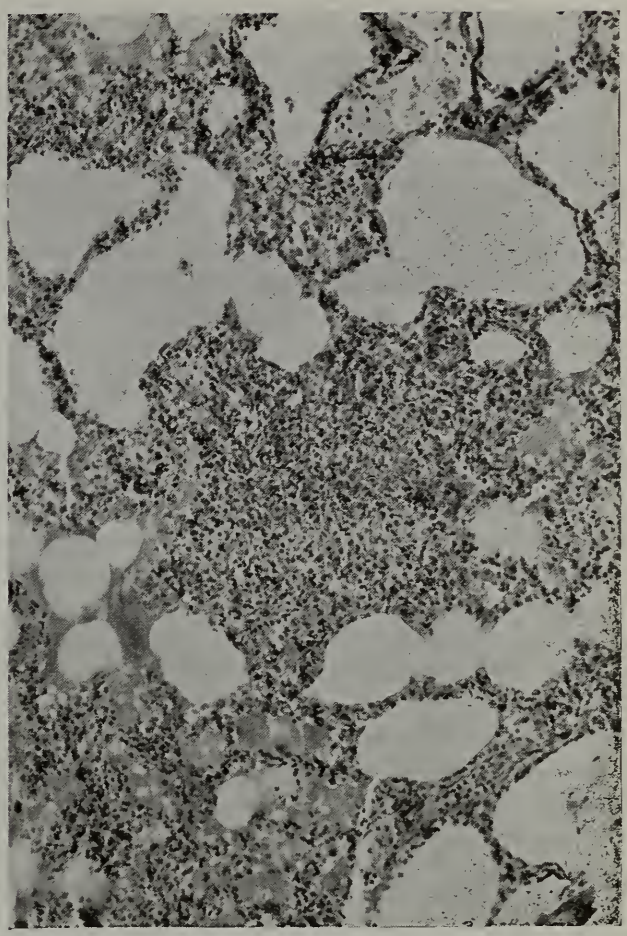


Figure 3—Lung: Focal necrosis and interstitial pneumonitis. X85.

evidences of acute passive congestion, particularly in the medullary part of the kidney. The glomeruli appeared relatively well preserved. There were no crystals in pelvis, tubules or interstitial tissue.

Lung—The lung, illustrated in Figure 3, showed lesions typical of patchy interstitial pneumonia. The alveoli in the involved areas contained macrophages and moderate amounts of serum. The alveolar walls were markedly thickened and very cellular. A few focal areas of necrosis could be seen chiefly confined to the cellular tissue of the alveolar wall. The central areas were undergoing dissolution; polymorphonuclear cells were beginning to accumulate at the periphery of the foci.

Spleen—The spleen showed no pathologic changes, except for signs of acute congestion.

Adrenals—There were a few scattered areas of focal necrosis chiefly confined to the superficial layer of the cortical substance. In addition, there were signs of acute congestion.

Heart—Sections were not available for study.

Brain—Sections from several lobes of both hemispheres from the hypothalamus and brain stem were stained with hematoxylin and eosin and cresyl-violet. Histologic examination revealed two principal types of abnormalities: (1) Vascular changes and (2) Alterations of the nerve tissue proper secondary to the vascular lesions.

(1) What appeared to be pinpoint areas of bloody discoloration to the naked eye were recognized as small veins and capillaries tremendously distended and engorged with blood. The majority of the smaller blood vessels disclosed signs typical of vasoparalysis. Many of the congested veins showed evidence of stasis and degenerative alterations of their walls. These changes were associated with an increased permeability of the vessel wall for serous fluids and blood cells. Some of the blood vessels contained hyalin thrombi.

(2) Changes of the nervous tissue proper, secondary to the vascular alterations, consisted of a moderate degree of edema, chiefly confined to the direct proximity of the smaller blood vessels. These changes were associated with a slight proliferation of glial cells, especially pronounced in the white matter.

The leptomeninges disclosed large accumulations of red blood cells. No inflammatory changes and no structural vascular alterations could be disclosed.

Summary of the Pathologic Fndings—It appears that the most uniform pathologic process consisted of small areas of focal necrosis, associated with proliferative changes of the interstitial tissue widely disseminated throughout the liver, kidney, lung and adrenals.

The histopathologic lesions encountered in the central nervous system consisted of vasoparalysis, petechial hemorrhages and secondary parenchymal changes in the form of moderate degree of edema and glial cell proliferation.

Diagnosis—Sulfathiazole toxicosis.

COMMENT

An undue reaction to sulfonomides which causes death is not uncommon. Though less frequent than those due to mechanical interference

with the kidneys, fatalities due to such a reaction are apparently growing in number.

In this case the patient expired approximately 48 hours after the appearance of the symptoms of sulfonamide intoxication despite the fact that the drug was discontinued at the first significant sign. The early symptoms of nausea and vomiting would not ordinarly be considered of any great portent, but here may have been evidence of early central nervous system involvement.

In view of the type of reaction elicited the high blood level of sulfathiazole can not be incriminated; it would simply indicate some drug retention even in the absence of oliguria. The clinical course and histopathology are similar to those of a group of cases which have been described[3,4,6,7]. In addition to the early miliary focal areas of necrosis scattered throughout the organs, there was also substantial evidence of severe encephalopathy and subarachnoid hemorrhage, conditions undoubtedly responsible for rapid collapse.

Although all of the organs were not available for microscopic study, it would seem from the nature and distribution of the lesions that the toxic reaction is generalized.

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The danger to others of communicable tuberculosis among elderly persons is great. Many of them are grandparents and it is not unusual to trace fatal tuberculosis in children and others to them. Casparis cited the case of several young Negro maids who had successively died while working in one home, or soon after. Investigation revealed the fact that an elderly white man in this home had communicable tuberculosis which was previously unsuspected.—J. Arthur Myers, M.D., Modern Hospital, April, 1944.

The B Vitamin Deficiencies in Clinical Medicine

By exact clinical diagnosis I am referring not to the frank deficiency pictures, which offer no serious diagnostic problem, but to the so-called "sub-clinical vitamin B deficiency," that vague and non-specific collection of symptoms which has become a universal source of worry to the clinician.

What are the symptoms and signs of subclinical or mild vitamin B deficiency? I have listed those which apply to children taken from the report of the National Research Council's Subcommittee on Medical Nutrition:

Symptoms:
- Lack of appetite.
- Failure to eat adequate breakfast.
- Failure to gain weight.
- Retarded muscular and mental development.
- Backwardness in school.
- Aversion to play.
- Inability to sit.
- Poor sleeping habits.
- Chronic diarrhea.

Signs:
- Pallor.
- Loss of subcutaneous fat.
- Poor muscle tone.
- Nasal blackheads and whiteheads.
- Rapid heart.

These symptoms are all non-specific and may be due to a great many factors, psychic or somatic, but the implication of those who prepared the list is that whatever else we do we ought to give B vitamins when we encounter any manifestation on the list.

I submit that this is not sound reasoning. In my opinion before we suspect a vitamin B deficiency we should have in addition to such symptoms, some evidence obtained from a careful history that a condition is present which may lead to B vitamin deficiency. Factors which may predispose to deficiency are the following:

1. Faulty diet.

2. Gastrointestinal disturbances, which interfere with absorption.

3. Circulatory disturbances, including shock, which interfere with the distribution of vitamins.

4. Conditions causing an increased demand for vitamins, such as prolonged fever, hyperthyroidism, pregnancy and lactation.

5. Faulty parenteral therapy — intravenous glucose without vitamin B supplements.

If, in the presence of one of these etiological factors—and incidentally they must operate for some time to induce deficiency—we get some of the suggestive symptoms listed above, our diagnosis rests on a sounder basis and therapy would seem justified.—L. Emmett Holt, Jr., M.D., Baltimore, Md. Nebr. State Medical Journal, Vol. 29, No. 10, Oct., 1944.

Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

ATYPICAL PNEUMONIA SIMULATING PULMONARY TUBERCULOSIS

FOR many years it has been the teaching of the medical profession to regard a patient subacutely ill with infiltrations of the upper lung fields in X-ray films as probably tuberculous unless proved otherwise. Recently it has become apparent that atypical pneumonia can produce lesions which at times are indistinguishable from pulmonary tuberculosis. This has been reported on several occasions. With the apparent increase in the incidence of atypical pneumonia, especially since the profession is becoming more conscious of it, it is evident that criteria for a differential diagnosis of these two conditions should be formulated.

CLINICAL OBSERVATIONS

The symptoms and clinical signs of atypical pneumonia have been adequately described in the current literature. The usual gradual onset of the disease, associated with malaise, generalized aches and pains, dry, nonproductive cough and fever may be simulated by any case of acute pneumonic tuberculosis. A differential diagnosis can not be made solely on the basis of the history and physical examination. Where serial roentgenograms are not feasible, the persistence of cough and expectoration, plus the findings of râles for a period greater than twenty-one days from the onset of the disease, should lead one to suspect tuberculosis even though the patient appears to be much improved.

ROENTGENOLOGICAL ASPECTS

In our seven cases of upper lobe atypical pneumonia two types of shadows were found on the films. The most common was an increase in the bronchial markings manifested by linear streaking densities with super-imposed mottled shadows. This was most marked at the hilum and, with an extension of the disease, would spread toward the periphery of the lung fields. The other type of finding was an area of increased tissue density in the parenchyma of the lung relatively uniform throughout and resembled the shadow seen in early pleural effusion. X-ray evidence of atelectasis was found in our cases only when the entire right upper lobe was involved. Complete involvement of an upper lobe will usually reveal some associated evidence of atelectasis, whereas in complete consolidation of a lobe due to pneumonic tuberculosis that is usually not the case.

Because there was such a wide divergence of roentgenological findings in our cases of atypical pneumonia it was felt that we could not make a definite differential diagnosis from a single film. In serial X-ray studies it was observed that cases of atypical pneumonia could be expected to show complete clearing of the chest involvement in from four to twenty days. If the serial roentgenograms still reveal a density twenty days after the onset of the illness, pulmonary tuberculosis must be seriously considered even if other evidence favors an X-ray diagnosis of atypical pneumonia.

In the case of a white soldier admitted to the hospital, the working diagnosis was atypical pneumonia of the right upper lobe. This was confirmed by roentgenogram. The patient had a low-grade fever for eight days following admission. A roentgenogram taken on the eleventh hospital day showed some clearing of the pneumonic process. The persistence of physical signs in the chest and the slow clearing of the chest lesion despite clinical improvement of the patient are not usual in atypical pneumonia so sputum examinations were began. Tubercle bacilli were found. This was confirmed in later examination of the sputum.

SUMMARY

1. Atypical pneumonia may simulate pulmonary tuberculosis both clinically and roentgenographically, and the reverse is equally true.

2. Approximately 7 to 10 per cent of atypical pneumonias have upper lobe involvement, which is the usual site for pulmonary tuberculosis.

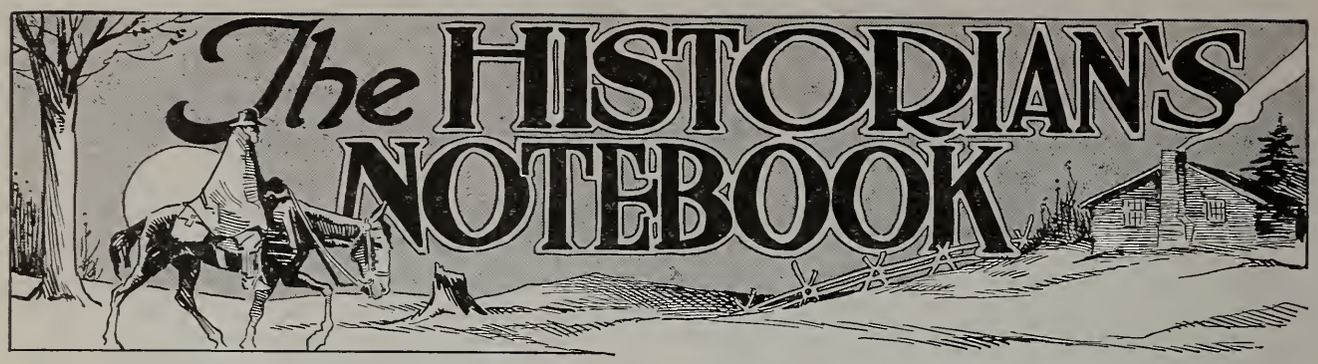
3. Serial roentgenograms showing apical lesions failing to clear in twenty days, following the onset of the disease, should raise the suspicion of pulmonary tuberculosis.

4. Sputum studies for tubercle bacilli are indicated in all doubtful cases.

5. If lesions persist for twenty days from the onset of the illness, and routine sputum studies are negative, further studies should be done, that is, sputum and gastric concentrates, and guinea pig inoculation.

6. Because of the apparent increase in the incidence of atypical pneumonia, the need for an early differential diagnosis is imperative.—Atypical Pneumonia Simulating Pulmonary Tuberculosis, J. S. Yoskalka, American Review of Tuberculosis, May, 1944.

The battle against tuberculosis is not a doctor's affair; it belongs to the entire public.—Sir William Osler.



Kept by David A. Tucker, Jr., Cincinnati, Ohio

The Bitter Pen

HOWARD DITTRICK, M.D.

LEADERSHIP provokes criticism. The more prominent the leader becomes the more virulent are the attacks of opponents. This is true as regularly seen in today's political campaigns. It was no less true in the early nineteenth century. In some old publications in the Cleveland Medical Library there appear attacks on Benjamin Rush and Daniel Drake.

In "The Rush Light," March 15, 1800, the editor mercilessly maligns Rush in this fashion: "a low-bred fellow, like Rush, whom the troubled motions of revolt had brought bubbling up from the mud of society." And Dr. Rush was a signer of the Declaration of Independence. In like manner Dr. Daniel Drake is treated with scorn by an eclectic critic.

Some of our older readers may remember similar incidents arising out of rivalry between different schools of practice or even between competing proprietary schools. In Cleveland, a century ago, the battle for students was the occasion of much picturesque overstatement and misstatement on the part of the Cleveland and Willoughby schools. How fortunate we are to live in an era when the bitterness of medical competition has been leavened by cooperation in preventive medicine and research. Inadequate schools have been eliminated, and Grade A schools have more applicants than they can accept. Numerous meetings of medical societies have afforded opportunity for rubbing shoulders. A competitor proves to be just another good fellow and when seen across the table has no sprouting horns.

The Author

● **Dr. Dittrick, Cleveland, Ohio, is a graduate of University of Toronto, Faculty of Medicine, 1900; and editorial director, Cleveland Clinic.**

Daniel Drake enjoyed a clash. He was frequently the center of a storm of some sort. It would be enlightening to read his comeback to the accompanying screed which appeared in the eclectic *Western Medical Reformer,* December 1846.

DRAKE ON QUACKERY*

The October number of the *Western Journal of Medicine,* published at Louisville, and edited by Drs. Drake and Yandell, has accidentally fallen into our hands. It contains, we observe, a letter from Dr. Drake on his favorite subject of Quackery. We like to see the Doctor thus riding his favorite hobby. Like the knight of the rueful countenance upon his Rosinante, no one can doubt that he is very appropriately mounted. The steed and the rider are so much alike, we cannot but admire the taste that brought them together.

Drake on Quackery! What a significant phrase! Who is there in the United States better fitted than Dr. Drake to expound the "Theory and Practice" of Quackery? Is there among the ranks of medical teachers a more notoriously unqualified and unsuccessful practitioner than Dr. Drake? Is there among all the ostentatious busy-bodies of the medical profession, a single individual whose real merits are so disproportioned to his public parade and pretension? Is there among medical teachers one whose gradu-

* Excerpt from *The Western Medical Reformer,* December, 1846, Vol. VI, No. 6, Cincinnati.

ates more generally discard his guidance and contemn his authority as a practitioner, when a small amount of experience has given them more practical views?

We think the most profitable lecture the Doctor could get up on his usual plan of "twenty-five cents admission" would be "a lecture on quackery, by Dr. Drake, illustrated by numerous cases from his own practice."

For the same reason that hypocrites love to denounce sinners, and rogues to raise the cry of "stop thief," Dr. D. is extremely fond of raising the cry of "Quack." Destitute of the magnanimity which usually characterizes the philosopher or the profound scholar, he is ever ready to assail opponents and rivals with the invective and ridicule which are adapted only to injure and disparage, without any reference to the merits of the parties.

Fertile in imagination, but feeble in his powers of argument and analysis, he is equally unsound in his opinions and deceptive in his assertions.—Self-interest is notoriously his constant ruling motive, and however plausible his course may appear in any instance, if examined carefully, selfish motives are found at the bottom of all. Hence, his unprincipled attempt to injure the Eclectic Medical Institute, by a gossiping letter to the Louisville Medical Journal, written and published at the proper time to meet the class of students gathering at Louisville, and fill their minds with the idea that Cincinnati was all a den of quackery from which a gentleman of any self-respect would turn aside with loathing and contempt. Knowing that the Eclectic Medical Institute was destined to be a formidable competitor in his future career, he takes especial pains to represent the Institute as a very contemptible affair. Thus by impressing his malicious falsehoods upon the minds of all within his reach, he hopes to play again the part in which he has been so conspicuous heretofore, as a fomentor of medical broils and general disturber of the harmony of the profession. He would fain induce the profession generally, to unite with him in urging war against this Institution and its graduates—not because its course of instruction is imperfect, or its professors unqualified—but simply because it stands in the way of Dr. Drake—because it contains men who are fully aware of his shallow incompetency, and because they are rising into high favor by their solid merits in a community in which his own powers are fully understood and his incompetency too well known.

Like most of the famous charlatans whose names are loudly trumpeted in the public ear, he is well aware that pecuniary success is his proper goal and his only compensation for the shifts and expedients of his notorious career. Hence, he is determined that the Louisville Medical Journal, with which he is now connected shall succeed "per fas et per nefas," even if success require an annual pilgrimage of electioneering to secure students and a busy circulation of slanders against his rivals. Yet, whenever a just appreciation of his character shall cause him to be ousted from that establishment, (an event not at all improbable), he will be as ready when he has opposing interests, to ridicule his former colleagues as he is at present to assail the Eclectic Institute. The ridicule of such an individual naturally excites the inquiry, as to what sinister object he may have in view, and in the present instance his motives are sufficiently apparent.

Without any specific statement or proof, he represents the Institute as a "den" of quackery, and relying as usual, upon his imagination, he represents it as the competitor of another den, the "Reformed Medical College of Ohio," in Cincinnati—an institution which has no existence but in his own corrupt distempered fancy. We have no disposition to retaliate this unmanly attempt against the Eclectic Institute of Cincinnati by enquiring into the merits of the Medical Institute with which Dr. D. is connected, but if it should become apparent that this course of ungentlemanly warfare against this Institute and its students is sanctioned as the policy of the Louisville Medical Institute, we shall not hesitate to show that we know when and how to "carry the war into Africa."

The True Symbol of Medicine

The unwinged staff with a single serpent is the sign and symbol of medicine and of its Grecian god, Aesculapius. The Roman caduceus is not such a sign, but is employed as an administrative symbol on the collars and chevrons of the Medical Corps of the Army of the United States. The caduceus merely implies the noncombatant status of the Corps in accordance with military usage; nevertheless this purely military and administrative symbol has too frequently become distorted into the sign of medicine (vide Arnold's paper in the *Bulletin of the History of Medicine*, May, 1943).

Krumbhaar, editor of the American edition of *Castiglione* and honorary president of the American Association of the History of Medicine, regards the adoption as an emblem by the Medical Corps, of the caduceus, sign of Mercury, god of commerce and of thieves, as "not an altogether happy choice".

It would probably be impossible to cite a more persistent (and stupid) confusion of symbols in the whole range of American culture.—Medical Times, p. 219.

Health and Human Resources in Rural Ohio

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Installment No. 3

(Continued from October, 1944, issue)

IN considering human losses and impairments, and in considering human conservation, it is necessary to remember that life is an ongoing, cumulative process. Whatever happens to the individual at one period of life is apt to affect him for better or for worse at each succeeding period. It is the purpose of this section to indicate some of the losses and impairments that occur at different age levels.

Prenatal loss and maternal deaths. An effective program for conserving and developing the individuals who make up rural communities must give attention to the prenatal period, for human losses as well as human gains start before birth. Large numbers of infants are not living when born. Still larger numbers are born prematurely, and for that reason have greatly reduced chances for survival. Furthermore, a considerable number of mothers die each year as a result of disease and injuries associated with pregnancy and childbirth.

In 1940 about 3,000 babies were stillborn in Ohio. In that year there were 26 stillbirths for each 1,000 babies born alive. The number of stillbirths per 1,000 live births in Ohio has been steadily declining. In 1925 the rate stood at 38. The 1940 rate of 26 for Ohio is, however, still unnecessarily high as indicated by lower rates in many other areas.

Maternal deaths in Ohio numbered 361 in 1940. This number amounted to 31 for each 10,000 births. This maternal death rate was fairly uniform between rural and urban areas; however, it has been declining very rapidly. It decreased by more than one-half between 1930 and 1940 and has continued to decline since 1940.

Exact figures on the number of premature births that occur each year in Ohio are not available. In 1940, however, there were 1,538 infant deaths resulting from premature births. It has been estimated that about two-fifths of the prematures die during the first months of life. Health authorities have listed some of the steps that must be taken to conserve the lives of mothers and unborn babies. These steps include better preparation of prospective mothers for the task of childbearing, including thorough medical examination, correction of all remediable defects, and nutritional upbuilding. First-rate medical and health services are important as is the maintenance of good family life.[11]

EDITOR'S NOTE: In this installment of his review of the health and human resources in rural Ohio, Mr. Mangus discusses the question of "Causes of Illness and Death at Different Age Levels". In the September and October issues of The Journal, he analyzed subtopics such as "Present Conditions of Rural Health" and "Demographic Conditions and Trends Affecting Health". Additional phases of the general subject will be discussed by Mr. Mangus in future issues of The Journal. Clip these installments of this interesting and important study. The medical profession should be well informed on this vital question.

The first year of life. One of the most hopeful trends in the field of human conservation has been the saving of the lives of infants under 1 year of age. A total of 4,744 babies died under 1 year of age in Ohio in 1940. This represents a rate of 41.4 deaths per 1,000 babies born alive, indicating a very large human loss. It is notable, however, that only one-half as many infants born in 1940 died during that year as would have died had they been born in 1920, when the infant death rate in Ohio was 82.9 per 1,000 births.

In spite of the very great progress in reducing deaths among babies, there is still far too much unnecessary loss during the first year of life. If all deliveries could be attended by skilled obstetricians, if all confinements could be restricted to places most suitable for birth, and if all babies could have the best of postnatal care, the infant death rate could be reduced by perhaps another one-half. This statement is borne out by the fact that in the city of Chicago where vigorous measures have been taken to save lives, during the first year the infant death rate has already been reduced to 28.4. Health authorities are pretty generally agreed that it is entirely possible through the best application of present knowledge to reduce infant mortality to at least 25 deaths under 1 year per 1,000 births. If this is correct then about 40 per cent of all annual

deaths under 1 year in Ohio in 1940 could have been prevented. This presents a most striking challenge to those concerned with the conservation of human resources.

In 1940 the infant death rate was 21.6 per cent higher in rural areas than in urban places of 10,000 or more population in Ohio and was nearly 12 per cent above the average for the entire state. The number of deaths per 1,000 births in Ohio in 1940 by place of residence of the mother was as follows:

Place of residence of mother	Deaths under 1 year	Infant death rate
Ohio (average)	4,744	41.4
Rural areas	1,804	46.2
Places of 2,500 to 10,000 pop.	495	44.1
Cities of 10,000 or more	2,445	38.0

The infant death rate within the rural population is not uniform throughout Ohio. In 1940 the rate per 1,000 births to mothers living in rural areas and in urban places up to 10,000 population was in inverse proportion to level of living in different sections of Ohio.[12] In the southeastern part of the state where the level of living is lowest there were in 1940, 23 more deaths under 1 year of age per 1,000 births than in the urban-industrial areas where rural level of living was highest. The situation is shown in the following table.

Level-of-living areas	Infant death rate (rural and town)	Births per 1,000 women 15-44 yrs.	Rural level-of-living index
All areas	45.7	78.2	100.0
Urban-industrial	39.4	67.6	135.0
Western-agricultural	43.4	83.4	106.0
Transitional	49.3	83.9	80.0
Southeastern	62.4	91.2	50.0

As is shown in this tabulation both birth rates and infant death rates among rural and town residents are closely associated with levels of living in different parts of Ohio. This suggests that one major attack both on differential reproduction and on losses under 1 year of age is to be found in improving the economic status of families.

The major causes of death among rural babies under 1 year of age in 1940 were as follows:[13]

Causes of death	Number of deaths	Per cent	Deaths per 10,000 births
All causes	1,804	100.0	461.7
Premature births	527	29.2	134.9
Pneumonia and influenza	374	20.7	95.7
Congenital malformations	206	11.4	52.7
Injury at birth	179	9.9	45.8
Diarrhea, enteritis, etc.	111	6.2	28.4
All other causes	407	22.6	104.2

Not only was the total incidence of deaths under 1 year of age very different between rural and urban areas in Ohio, but the incidence of death from specific causes also differed notably. The pattern of causes for infant deaths in the cities is shown in the following table:[13]

Causes of death	Number of deaths	Per cent	Deaths per 10,000 births
All causes	2,445	100.0	379.8
Premature births	850	34.8	132.0
Congenital malformations	346	14.2	53.7
Pneumonia and influenza	290	11.9	45.1
Injury at birth	277	11.3	43.0
Diarrhea, enteritis, etc.	123	5.0	19.1
All other causes	559	22.8	86.9

It is evident from a comparison of causes of infant deaths shown in the two preceding tables that the higher incidence of death from infections accounts for the greater loss of life among babies born to rural mothers. Since a very large proportion of all infant deaths occur during the first week of life, it is likely that the greater saving of babies in the cities is due in large part to the prevention of infectious diseases, such as influenza and pneumonia, among babies born in hospitals.

There is no information available regarding the amount of the non-fatal illness among rural or urban infants under 1 year of age in Ohio. Evidence from the National Health Survey indicated an annual rate of 120 cases of disabling illness per 1,000 births among those under 1 year of age in the survey. Acute respiratory diseases constituted the major cause of illnesses among babies.

Steps that need to be taken in the conservation of life and health during the first year are well known among health authorities. Chicago experience shows that preventive measures are particularly applicable in cases of prematurity, birth injuries, and infections.[14]

Experience has shown that the chance of survival of a prematurely born baby can be very greatly increased by creating for it an environment favorable to prematurity. This requires specially equipped and staffed nurseries, incubator ambulances, a certain supply of human milk, and expert nursing service following hospital discharge.

Infectious diseases in young infants can best be controlled by having all births occur in separate delivery and convalescent rooms in hospitals, with special maternity duty nurses and with careful aseptic practices. Birth injuries such as cerebral hemorrhage, can be greatly reduced through improvement in the practice of obstetrics.

There are some authorities who feel that there is a conflict between the physical and emotional needs of babies born in hospitals. Some feel that the young infant needs closer contact with the mother and less routine than is practiced in

modern hospital treatment. Other steps that need to be taken to conserve life in its early stages include good family life, improved housing, sanitation and nutrition, and improved health services of all kinds, including the services of pediatricians.

Children 1-14 years old. During the past twenty years the declining birth rate has greatly reduced the child population in rural areas of Ohio. During this period the child population has been reduced both in total numbers and in its proportion of the total rural population. In 1920, for example, children of ages 1-14 inclusive, comprised 33.7 per cent of the rural-farm population of Ohio. In 1940 children of these ages made up a little less than 25 per cent of the farm population.

With the decline in numbers of children has come an increasing realization of the pre-school and elementary school years from the point of view of human conservation. Death rates among children after the first year of life are lower than for any other period in the age span. Of the 26,000 deaths to rural residents of Ohio in 1940, 786, or 3.0 per cent were children of pre-school and elementary school ages. The death rate among these children was 1.4 per 1,000.

The major causes of death differ greatly between those of school age and those too young to attend school. Among children 1-4 years of age influenza and pneumonia account for about 22 per cent of all deaths that occur. The other leading causes of death at the pre-school ages are congenital malformations, diarrhea, enteritis and other gastro-intestinal disorders, motor vehicle accidents, and tuberculosis. About 1 out of each 5 deaths among children 5-14 years of age in 1940 was due to motor vehicle accidents and accidental drownings. Influenza and pneumonia, heart diseases, and appendicitis constituted the other leading causes which together accounted for 23.4 per cent of all deaths in this age period.

The sickness survey conducted by the Committee on the Costs of Medical Care indicated that illness rates were highest among children under 5 years of age, and next highest among children 5-10 years old. The illness rate was much lower, however, for children 10-14 years old. The National Health Survey indicated that the annual rate of disabling illness was about 300 per 1,000 children between the ages of 1 and 9. During this entire age span, respiratory diseases and the communicable diseases of childhood comprise the major causes of illness.

Of even greater significance perhaps than physical illness and death among young children is the fact that during the early years of life the major bases of future mental and emotional health, or ill health are laid down. Largely during the pre-school years the child's major patterns of social and personal adjustment are fashioned out of parent-child relationships and family training.

Personality deviations and distortions as a result of mismanagement during the early years are apt to become persistent personality trends. These may handicap the child in meeting his immediate problems and may crop up in later years in chronic mental and emotional ill health. Probably the major task in conserving and developing the human resources represented in children is to improve the home and family situations so that the child can be reared wisely and sanely. This calls for education for family living, parent education, and mental hygiene and child guidance service.

Youths 15-24 years old. The period of life extending from 15-24 years of age is usually considered the most healthy of any age period. At this time death rates are near the minimum and illness rates are lower than for any other age period.

In 1940 there was a total of 1,832 deaths among white youths of Ohio of whom 681 were rural residents. This number of deaths amounted to about 1.7 per 1,000. Motor vehicle accidents accounted for 18.5 per cent of all deaths at this age period, and tuberculosis causes an equally large proportion of the deaths. The other leading causes were heart diseases, influenza and pneumonia, and maternal deaths among the young women.

In spite of the comparatively low incidence of deaths and of acute illnesses among youths, nevertheless the draft experience has uncovered a surprisingly large amount of chronic disabling or partially disabling defects among young men. This is well illustrated in a recent report dealing with the health defects of 18 and 19 year old registrants.

One out of each four 18 and 19 year old selective service registrants has been found unfit for general military service. This fact is based on a sample study of 45,585 boys examined at local draft boards and at induction stations in December, 1942, and in January and February, 1943. The study was made by the National Headquarters of the Selective Service System and was published in a recent issue of *The Journal of the American Medical Association.*[15]

The rejection rate for farm workers among the teen-age registrants was higher than that for any other major occupational group and was 62 per cent above the average for all examinees. It was found that 41.1 per cent of those boys who reported farming as their major occupation were rejected as compared to an average rejection rate of 25.4 per cent. Only emergency workers and the unemployed approached the high rejection rate among the farm workers. White

collar workers had a rejection rate only one-half that of the farm group.

The causes of rejection of the teen-age registrants are of major interest particularly because of the high incidence of mental illness among them. "Mental disease", consisting largely of several types of psychoneuroses, constitutes one of the two most frequent causes for rejections, be ing topped only by defective eyes. "Mental disease" accounts for a little more than one-tenth of all the rejections and this cause, together with other mental and nervous defects including mental deficiency, neurological defects, and educational deficiency, accounts for more than one-fourth of all rejections.

The leading causes for rejection for the 18 and 19 year old examinees are shown in the following table:

Type of defect	Per cent of rejectees	Rejection rate per 1,000 examined
Total all causes	100.0	253.5
Eyes	17.7	44.9
Mental disease	10.9	27.6
Musculoskeletal	9.0	22.7
Cardiovascular	8.4	21.4
Ear	5.9	15.0
Hernia	6.4	16.3
Neurological	5.8	14.8
Educational deficiency	7.7	19.5
Syphilis	4.0	10.2
Underweight	2.8	7.1
Mental deficiency	2.8	7.0
Tuberculosis	2.7	6.8
Lung defects (except t. b.)	2.4	6.0
All other causes	13.5	34.2
Number examined	45.585	45,585

Statistics on cause for rejection are not available for farm and nonfarm youths separately. It is doubtful whether the pattern of causes is greatly different for the farm and nonfarm groups.

Teen-age youths presumably represent the healthiest age group in the population. The high incidence of physical and mental defects found among those examined for selective service is, therefore, indicative of something seriously wrong with the conditions under which people live.

Particular emphasis needs to be given to the high rates of mental illness being uncovered by the selective service examinations because mental health is a field that has not received the attention it deserves. That large proportion of rejectees labeled psychoneurotic do not represent persons lacking in intelligence, but persons who are personally and socially maladjusted. It may be assumed that those youths who are so maladjusted that they are unfitted for army life are also unfitted to meet adequately the everyday issues of civilian life.

The roots of most present-day mental illnesses are social, cultural, and psychological as psychitrists, social psychologists, and sociologists have recently discovered. Such illnesses when they are established are often difficult to cure, but mental and social hygiene measures may be developed for prevention. Both therapeutic and preventive measures should become a major concern of the social scientist and of the public policy maker interested in public health programs for rural as well as for urban people.

An adequate rural health program must include not only the ordinary medical, dental, and hospital provisions, but also mental and emotional health and hygiene services of various kinds.

The adult years 25-44. Persons of these ages comprise almost one-fourth of the rural-farm population of Ohio and somewhat more than one-fourth of the rural-nonfarm population. Upon these young adults rests a large share of the responsibility for economic production and for child-rearing. Losses through illness, impairments, and deaths become increasingly severe during these years. During the post-war years a considerable proportion of the men in these early adult years of life will be comprised of veterans of the present war. Hence, the prevalence of physical and mental impairments, and the incidence of need for health services and conservation will be very greatly increased.

During peace times the death rate among adults rises steadily with increasing age. In 1940 the death rate among rural residents 25-34 years of age was 2.5 per 1,000. Among those 35-44 years of age the death rate was 4.1 per 1,000.[16]

The survey of illness made by the Committee on the Costs of Medical Care indicated that persons 25-44 years of age suffer 400 to 500 cases of disabling illnesses per 1,000 annually. The major causes of illness were respiratory diseases, disabilities associated with childbearing, digestive disorders, accidents, and nervous and mental disturbances. This last cause is reflected in increasing rates of admission to mental disease hospitals. The total amount of impaired efficiency due to nervous and emotional distress in the early adult years cannot be estimated. All indications are, however, that it is very great.

A total of 6,535 white persons in this age interval in Ohio died during 1940. Of these deaths 1,908 occurred to rural people, a number which amounted to 3.2 per 1,000 of these adults. The major causes of deaths to white adults in Ohio are shown in the following table:[17]

Causes of Death	Per cent of all causes
All causes	100.0
Diseases of heart	15.0
Tuberculosis	10.8
Cancer	11.2
Motor vehicle accidents	8.1
Influenza and pneumonia	4.9
All other causes	50.0

A good indication of the extent of health defects and impairments in the young adult male

population of the pre-war period is to be found in the results of the selective service examinations. During the pre-war period extending from November, 1940, through September, 1941, a total of around 3,000,000 registrants were examined throughout the United States. During this peacetime period physical and mental standards for military service were set higher than they were during wartime. Of these registrants physically examined before Pearl Harbor, 52.8 per cent were rejected either at local boards or at induction stations.

The following table[18] shows the principal causes of rejection arrayed in order of their importance.

Principal causes of rejection	Per cent of registrants rejected	Per cent of distribution of rejections
All causes	52.8	100.0
Teeth	8.8	16.5
Eyes	6.2	11.7
Mental and nervous	5.5	10.4
Cardiovascular	5.3	10.0
Musculoskeletal	4.7	8.9
Hernia	3.0	5.9
Venereal disease	3.1	5.9
Ear, nose, throat	2.9	5.5
Tuberculosis, lung diseases	2.0	3.8
Educational deficiency	2.0	3.8
Feet	1.6	3.0
Underweight	1.5	2.9
Other	6.2	11.7

While the average rejection rate among pre-Pearl Harbor draftees was 52.8 per 100 examined, there was a regular increase in rejection rates with advancing age. For example, among the youngest men examined approximately 22 years of age, there were 41.6 rejections per 100. This rate increased more than 3 per cent for each additional year of age until it reached 80.3 per cent for those 36 years old.

It must be recognized that many of the defects responsible for rejection for military service are not of such nature as to hinder seriously the performance of ordinary civilian functions.

Perhaps the major task of human conservation in these adult years is that of providing both curative and preventive medical care and mental hygiene services to all who need them.

Later maturity 45-64 years. Persons in the later adult years, 45-64, comprise increasingly large numbers and proportions of the total population. Such persons comprised only 17.7 per cent of the population of Ohio in 1920, while in 1940 they comprised 21.6 per cent. People in this age interval comprised 19.5 per cent of the farm population in 1920, but made up 22.6 per cent of that population in 1940.

Increasing mental and physical illnesses together with disability and death from the degenerative diseases constitute major hazards to human conservation in this period of life. During these years the chances of death increase rapidly with each successive year. In 1940 the death rate among rural persons 45-64 years old was 12.6 per 1,000. The death rate was, however, more than twice as high in the second half as in the first half of this age period, being 8.1 for those 45-54 years old and 18.3 for those 55-64.

The leading causes of death among persons comprising the white population of Ohio 45-64 years old in 1940 were as follows:[19]

Causes of Death	Per cent of all causes
All causes	100.0
Heart diseases	27.9
Cancer	17.6
Intracranial lesions	8.8
Nephritis	6.2
Influenza and pneumonia	4.3
Other causes	35.2

As shown in this table the majority of deaths during these years result from the breakdown of the vital organs—the heart, brains, and kidneys, and from malignant growths of cancer. Unfortunately no effective treatment of advanced cases of these degenerative diseases and of cancer has been discovered. As a result death rates among people in the advanced years of life have shown comparatively little decline during the entire period for which mortality statistics are available. Hence, while the average length of life at birth has increased by 30 per cent since 1900, the average length of life at 40 has increased only about 10 per cent during the same period. The gains in average length of life are still smaller beyond the fortieth year (Table 6).

Table 6. Change in the Expectation of Life at Different Ages in the White Population of the United States, 1900-1940

Age	Males			Females		
	1900	1940	Per cent increase	1900	1940	Per cent increase
Birth	48.2	62.6	29.9	51.0	67.0	31.4
10 years	50.6	56.9	12.5	52.2	60.6	16.1
20 "	42.2	47.7	13.0	43.8	51.2	16.9
30 "	34.9	38.7	10.9	36.4	42.1	15.7
40 "	27.7	30.0	8.3	29.2	33.1	13.4
50 "	20.8	21.9	5.3	21.9	24.6	12.3
60 "	14.4	15.0	4.2	15.2	16.9	11.2
70 "	9.0	9.4	4.4	9.6	10.4	8.3
80 "	5.1	5.1	.....	5.5	5.8	5.5

Source: Dorn, Harold F., "Change in Mortality Rates, 1930-1940", The United States Public Health Service, **Public Health Reports**, Vol. 57, Part II, December 4, 1942. pp. 1,858-1,868.

The process of growing old is inevitable and beyond human control. There is evidence, however, that much of the breakdown and premature aging that occurs in these later adult years is a result of accumulated defects and disabilities carried over from the earlier years of life. Effective programs of human conservation in all of its aspects during infancy, childhood, youth, and early maturity offer that which is perhaps the most hopeful approach to the protection of life in the later years.

Aged persons 65 years old and over. With

aged people increasing in numbers and in their proportion of the total population, there is urgent need for effective planning to provide for their special needs. Aged people suffer not so much from the physical effects of old age and senescence as from the cumulative effects of damaged hearts, brains, and kidneys, from cancer, and from the intense emotional strains accompanying loss of useful functions in the community.

Among rural residents of Ohio the death rate rises rapidly after 65 years. In 1940 the death rate stood at 42.9 among those 65-74 years old. It rose to 118.0 for those 75-84, and to 254.3 for those 85 years old and over.

The causes of death among aged white persons in Ohio in 1940 were as follows:[20]

Causes of Death	Per cent of all causes
All causes	100.0
Heart diseases	36.0
Intracranial lesions	13.7
Cancer	12.0
Nephritis	9.0
Influenza and pneumonia	5.7
Other causes	23.6

These statistics show that about half of the deaths of these aged people of Ohio result from heart diseases and from intracranial lesions, mostly cerebral hemorrhage. These together with cancer, nephritis, influenza and pneumonia account for three-fourths of all deaths among these old people.

Now that a large proportion of people are living beyond 65, there is a greater need than ever before for effective social action aimed at making old age a happy and socially useful period in life. One approach is to conserve and develop health to the maximum at all preceding ages, so that fewer persons will reach old age with an accumulation of handicaps, defects, and impairments.

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16. U. S. Bureau of the Census, *Vital Statistics Rates in the United States, 1900-1940,* Table II, p. 205.

17. U. S. Bureau of the Census, *Summary of Vital Statistics for Ohio, 1940,* Table K, p. 1,071.

18. National Headquarters, Selective Service System, *Causes of Rejection and Incidence of Defects,* Medical Statistics Bulletin No. 2, p. 6.

19. U. S. Bureau of the Census, *Summary of Vital Statistics for Ohio, 1940,* Table K, p. 1071.

20. U. S. Bureau of the Census, *Summary of Vital Statistics for Ohio, 1940,* Table K, p. 1071.

(To be continued)

Christmas Seal Sale to Start in Ohio on November 27

Christmas Seals will go on sale throughout Ohio on November 27, for the purpose of raising funds to support the work of the National Tuberculosis Association, the Ohio Public Health Association and 88 county-wide health associations in their fight against tuberculosis. The seal



sale in Ohio is held in conjunction with the nationwide sale and will continue until Christmas.

The total amount raised in Ohio last year was $740,000. Proceeds of the sale are distributed as follows: Eighty per cent is retained by the local group for use in the community; 15 per cent is apportioned to the Ohio Public Health Association and five per cent goes to the National Tuberculosis Association.

Dr. Howard Holmes Appointed to Public Health Council

Dr. J. Howard Holmes, Toledo, has been appointed a member of the Ohio Public Health Council by Governor John W. Bricker. Dr. Holmes succeeds the late Dr. Ward D. Coffman, Zanesville, and will serve for the remainder of the latter's unexpired term, ending June 30, 1950.

A graduate of Ohio State University College of Medicine in 1920, Dr. Holmes is chief of staff of Lucas County General Hospital and member of the staff of Toledo and Women's and Children's Hospitals; superintendent of the Bureau of Tuberculosis Control of the Toledo Health Department; director of the Toledo Tuberculosis Clinic; president of the Toledo Public Health Association; and a member of the Council of the Toledo Academy of Medicine. Dr. Holmes is a Fellow of the American Medical Association and the American College of Chest Physicians.

WAR NOTES

Hospital admission records show there has been a striking decline in the incidence of many diseases in this war compared with the first World War, Major General George F. Lull, Deputy Surgeon General of the Army, told the International College of Surgeons which met at Philadelphia last month. The pneumonia rate, he said, has dropped from 19.0 to 12.8, the measles rate from 23.8 to 5.8, mumps from 55.8 to 6.2, scarlet fever from 2.8 to 1.6, meningococcic meningitis from 1.2 to 0.8, tuberculosis from 9.4 to 1.2 and venereal disease from 86.7 to 41.0. These figures represent annual hospital admission rates per thousand strength. Similarly the death rate from all diseases dropped from 14.1 in World War I to 0.6. The Army's influenza rate, which was 5.97 per one thousand in World War I has become negligible, being less than one per one hundred thousand strength.

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The Legion of Merit has been presented to Lt. Col. Maurice M. Kane, Greenville, for outstanding services as a commanding officer of a medical battalion in the 88th Infantry Division on the 5th Army front in Italy. Starting with a small cadre of trained personnel, he brought the battalion to a high level of accomplishment and to a position of one of the outstanding units of the division, his citation said, commending him for "contributing greatly" to his division's successful performance in combat.

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Because of the urgent need for Medical Corps officers for overseas assignment, a survey is being made of all those in the Army Service Forces who are now on permanent limited service with a view to their possible reclassification, according to a recent order.

* * *

Major William B. Bean, Cincinnati, of the Armored Medical Research Laboratory, Ft. Knox, Ky., directed the most entensive controlled ration test ever conducted using U. S. Military personnel, according to a news release received from the Office of the Surgeon General, Technical Information Service. American and Canadian expeditionary rations were used, and the results were "highly satisfactory". A battalion of American soldiers on maneuvers at an altitude of 8,850 feet above sea level in Colorado were fed exclusively on American C, K, 10 in 1, and Canadian Mess Tin B ration for a period of 60 days. During this time they were engaged in vigorous combat training. At the conclusion of the test it was found that the troops were in better physical condition than at the start, with high morale. The rations were proven to be wholly adequate to sustain troops in vigorous combat. Certain items in the rations, however, were found to be less acceptable to the men than others, and these will be improved.

Physicians who attended the State Association Regional Postgraduate Lectures at McConnelsville, Dennison, Springfield and Piketon in November, 1941, will recall that Dr. Bean, then assistant professor of medicine at the University of Cincinnati College of Medicine, was one of the speakers.

* * *

Capt. Geo. B. Watson, Columbus, busy caring for Merrill's Marauders in a general hospital unit in Assam, India, recently met Dr. Gordon Seagraves, author of "Burma Surgeon". Capt. Watson's opinion of India coincides with that of the other Ohio docs who have written us from over there. 'Nuf sed!!

* * *

From Kwajalein Island, Kwajalein Atoll, writes Capt. Harold C. Ziegler, Toledo, that he hopes to return soon to his wife and ten-month old twin daughters in Honolulu.

* * *

Comdr. Paul L. Yordy, Dayton, formerly on duty at San Diego, is now giving anesthetics "in the largest Naval hospital in the Pacific". He says: "That should give you some idea of my present location". Our guess is "Hawaii". His immediate chief is Comdr. Stanley Gardner, Cleveland.

* * *

Lt. Col. Arthur G. King, Cincinnati, in "the relatively placid position" of Executive Officer to the Post Surgeon at Camp Breckenridge, Ky., says: "It is a big let-down from the excitement of my overseas work, but as compensation there are many Buckeye medical officers here, and the locale is within reasonable distance of Ohio".

* * *

From the Public Relations Office of the Y-Force Operations Staff in China, comes word of the promotion to Lieut. Col. of Major Eugene J. Stanton, chief surgeon of that staff. According to the news release. "Col. Stanton was an instructor at Western Reserve when he entered

the Army in Sept., 1941. Ordered overseas from field maneuvers in the desert near Camp Young, Calif., he arrived in India in January, 1943. For several months he was assigned to the X-Force along the Ledo Road, where his unit set up the first chain of medical evacuation facilitations for the troops—Chinese and American—working in the jungle to develop the road. He was sent to China in May, 1943, and assigned to the Y-Force Operations Staff, the large American liaison group which is engaged in assisting the Chinese armies to reopen the Burma Road. Y-Force trains, supplies and advises the Chinese troops, also furnishes medical supplies to Chinese army hospitals and trains Chinese medical men in modern American Military medical techniques."

* * *

After many months of rugged duty with the First Marine Division at Guadalcanal, Cape Gloucester, New Britian, etc., Lt. Comdr. T. E. Newell, Dayton, is on the staff of the U. S. Naval Hosp., Ft. Eustis, Va.

* * *

Evacuated to the United States two months ago following a jeep-truck accident in New Guinea, Capt. L. N. Shroder, Greenville, is a patient at Percy Jones General Hospital, Battle Creek, Mich.

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Lieut. R. C. Novatney, Elyria, who received his flight surgeon's designation at the Miami Naval Air Station in April, is now addressed at Composite Squadron, No. 19, care of Fleet Post Office, New York.

* * *

Capt. Carl D. Marsh, Springfield, with a general hospital in New Guinea, received a commendation for his work as consulting allergist and dermatologist for another hospital unit.

* * *

"Everything is running smoothly" with his service group in India, writes Capt. John R. Scherer, Portsmouth.

* * *

A note of appreciation comes from Major Jack A. Rudolph, Columbus, chief of the allergy section at Oliver General Hospital, Augusta, Ga.

* * *

Maj. F. R. Kelly, Cleveland, chief of the surgical service, 129th Evacuation Hospital, Ft. Riley, Kan., is at the Mayo Clinic, Rochester, Minn., for a 12-week course in general surgery and surgical specialties.

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Capt. Franklin D. Radabaugh, Pandora, is serving "somewhere in China".

* * *

Recently transferred from the Air Service Command to the Air Transport Command, and expecting overseas assignments soon, Capt. Frank W. Anzinger, Springfield, and Capt. E. D. Peelle, Wilmington, are assigned to the Flight Surgeon's Office and the medical service at the Station Hospital, Fairfield, Calif. Capt. Peelle formerly was chief flight surgeon at Patterson Field, Dayton, and Capt. Anzinger was assistant chief of medicine at Tinker Field, Okla., for 13 months.

* * *

Maj. H. B. Peck, Mansfield, at the Station Hospital, AAF, Yuma, Ariz., to which he was recently assigned, has "a whopping practice" in ENT, "what with the heat, dust and coolers".

* * *

Lt. M. D. Shilling, Ashland, is a ship's medical officer, care of FPO, San Francisco. He had previously been on duty with a harbor installation at Port Hueneme, port dispensary at Camp Rousseau and seven weeks' training aboard a ship out of San Pedro.

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Lt. Comdr. J. Fred Smith, Montpelier, has joined the Ohio contingent in New Guinea.

* * *

Writes Maj. Richard W. Weiser, Cincinnati: "Within a very short time I'll be returning to the states after 32 months overseas. All of that time I've received *The Journal* regularly though I have moved around considerably . . . I have no idea where I'll be assigned after my leave." Maj. Weiser was with the Fourth General Hospital (Lakeside Unit) in the South Pacific. *The Ohio State Medical Journal* will be there to greet you, doctor, when you rejoin your family at Columbia, S. C.

* * *

These four Ohioans did a bit of reunioning recently in Normandy: Lt. Col. George L. King, Alliance; Lt. Col. Claude S. Perry, Columbus; Major Dorrence S. James, Delaware, and Major Fred J. Hunter, Jr., a graduate of O.S.U. in 1934, who was practicing in New York City when he entered the service in 1942.

* * *

Tetanus has been virtually eliminated from our armed forces as a result of compulsory immunization, according to a recent statement by Major General Norman T. Kirk, Surgeon General of the Army. He said that not a single case has been reported among completely vaccinated troops, and there has only been a handful of cases throughout the entire Army. The most recent account illustrating the value of tetanus immunization was given in the report of a Navy medical officer who served aboard a hospital ship on which 284 Japanese and 343 Americans, all wounded in the same engagement, were being treated. Fourteen cases of tetanus, ten of which were fatal, occurred among the Japanese. None

of the Americans developed the disease. Army medical records indicate that the Japanese do not immunize actively against tetanus.

* * *

A course for medical officers in front line psychotherapy given in a station hospital in England by Major Howard D. Fabing, Cincinnati, for nearly a year before the invasion of France, is interestingly described in an article entitled "First Aid for Battle Shock", by Albert Q. Maisel in the October issue of the *Cosmopolitan*.

* * *

Lt. William Deffinger, Cincinnati, has been cited by the Secretary of the Navy for heroic performance of duty with the Second Marine Division in Tarawa on Nov. 23, 1943. Home on a 15-day leave after 22 months "out there", Lt. Deffinger reported that his experiences at Tarawa were mild compared to what happened at Saipan when he went in with the first Marine assault force as a battalion surgeon. He was also on Tinian and Guadalcanal.

* * *

Lt. Comdr. W. F. Lyons, Coshocton, formerly medical officer for the Navy's V-5 Pre-Flight School at Ohio Wesleyan University, Delaware, is now stationed on Anguar Iland in the Palau group in the South Pacific. The V-5 program at Delaware was discontinued this past Summer.

* * *

Lt. (j.g.) Howard M. Schriver, Cincinnati, son of Dr. L. Howard Schriver, President of the Ohio State Medical Association, has reported for active duty at the U. S. Naval Hospital, Santa Margarita Ranch, Oceanside, Calif. He recently completed a residency at Cincinnati General Hospital. Dr. Schriver, Sr., was a first lieutenant in the Army Medical Corps in World War I, serving a year in France with Base Hospital 25.

* * *

In the October issue of War Notes, Dayton was listed incorrectly as the home-town of Lt. Comdr. Joyce I. Hartman, now on duty at the U. S. Naval Hospital, San Diego, Calif. Dr. Hartman practiced in Cleveland prior to being commissioned in the Navy.

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Fletcher General Hospital, Cambridge, reached its full 1,500 bed-capacity for the first time with the arrival, on October 12, of 135 sick and wounded veterans of the European war theater.

* * *

From Assam Province, India, writes Capt. George H. Lemon, Fayette: "The July and August *Ohio State Medical Journal* came in the last two days. I haven't had time to read the whole *Journal*, but Capt. Patterson and I read every word about the men in the service. It is the only way we can keep track of our friends, and believe me, it means a lot. Capt. Owen F. Patterson (Holmesville) and I are with the—Medical Air Evacuation Transport Squadron in India. There is little work to do now since the fall of Myitkyina, but we have both been in Burma, Calcutta, Karachi and other spots in India on Air Evacuation activities. Since the monsoon season is nearly ended we may see some renewed activity in Burma. If the rest of the Ohio physicians appreciate getting *The Journal* sent to them as much as I do, the Ohio State Medical Association should be the strongest association in the United States after the war. Thanks again. . ."

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Recently returned from Italy, where he was CO of a station hospital, Lt. Col. A. A. Hall, Columbus, is the new chief of the medical service of Fletcher General Hospital, Cambridge.

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Capt. Morris Wilderom, Medina, is a patient in Crile General Hospital, Cleveland, recovering from injuries received in an accident in England.

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The Office of the Surgeon General has announced that with the peak of the Army's dental work load past, several hundred dental officers will be relieved from active duty with the Army shortly, permitting their return to private practice.

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Serving in China with the India-China Wing, Air Transport Command, Capt. Edw. W. Sanders, Bellevue, recently received his third commendation from his commanding officer for outstanding performance of duties as medical officer and flight surgeon.

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Most of our new addresses are APO's or FPO's —which we are not permitted to publish, but here are some within the continental boundaries of the United States: Maj. Louis S. Zwick, Wadsworth, MDRP, Billings Gen. Hosp., Ft. Benjamin Harrison, Ind.; Lt. Dean W. Mallett, Springfield, Army-Navy Gen. Hosp., Hot Springs, Ark.; Maj. Jos. J. Joelson, Cleveland, Crile Gen. Hosp., Cleveland; Capt. Merl B. Smith, Toledo, Section E, 2117th AAF Base Unit, Buckingham Field, Ft. Myers, Fla.; Lt. Comdr. Joseph B. Bolin, Norwood, U.S.N. Trg. and Dis. Center, Special Augmented Hosp., No. 6, Shoemaker, Calif.; Capt. Edward C. Klopfer, Columbus, Sta. Hosp., Erie Proving Grounds, LaCarne, Ohio; Maj. R. D. Snyder, Dayton, 62nd Field Hosp., Ft. Knox, Ky.; Capt. Howard J. Murphy, Toledo, Stark Gen. Hosp., Charleston, S. C.; Lt. Comdr. E. J. Ryan, Cleveland, U. S. Naval Air Station, Main Dispensary, Jacksonville, Fla.; Capt. Sam S. Chudde, Dayton, AAF Dispensary, Palm Springs AAF, Palm Springs, Calif.; Capt.

Paul W. White, Lorain, Sta. Hosp., AAB, Delhart, Texas; Maj. Leo S. Friedman, Cincinnati, AAF Base Unit Sqdn. H., AAF Regional Sta. Hosp., Hunter Field, Savannah, Ga.; Capt. Abraham Steinberg, Toledo, Camp Barkeley, Texas; Maj. Frank Bly, Akron, Wakeman Gen. Hosp., Camp Atterbury, Ind.; Lt. S. E. Flook, Dayton, U.S.N.H., Fort Eustis, Va.; Capt. Saul I. Krasne, Wickliffe, P. W. Camp, McAlester, Okla.; Capt. P. A. Price, Toledo, Sta. Hosp., AAF, McCook, Nebr.; Capt. P. B. Zollett, Cleveland, Veterans Hosp., Dayton; Maj. Edward A. Gall, Cincinnati, Valley Forge Gen. Hosp., Phoenixville, Pa.; Capt. Elmer D. Engelman, Chillicothe, Med. Sec., Fort Lewis, Wash.; Lt. Comdr. J. D. Bolin, Norwood, Naval Adv. Pers. Depot, San Bruno, Calif.; Capt. R. L. Haas, Dayton, Hill Field, Ogden, Utah; Capt. David Magid, 112th Evac. Hosp., Camp Barkeley, Texas; Capt. James J. Pagano, Canton, 4th OTU, Brownsville, Texas; Capt. L. C. Goldberg, Cincinnati, Oliver Gen. Hosp., Augusta, Ga.; Lt. Col. Wm. B. Wartman, Cleveland, Dibble Gen. Hosp., Menlo Park, Calif.; Capt. Samuel Gendelman, Manchester, Sta. Hosp., Will Rogers Field, Oklahoma City, Okla.; Lt. Comdr. James E. Vollmer, Cincinnati, Naval Officer Procurement, Cincinnati; Lt. Taylor W. Barker, Cincinnati, AMP Tng. Base, BND, Ocean Side, Calif.; Lt. Howard W. Smith, Ashland, 438th Med. Bn., Co. D, Camp Howze, Texas; Capt. Leo Levin, Cleveland, Sta. Hosp., Camp Callan, Calif.; Comdr. W. M. Johnson, Akron, U. S. Naval Hosp., Banning, Calif.; Maj. Herman H. Ipp, Youngstown, Field Hosp., Ft. Knox, Ky.; Maj. Harold D. Waltz, Sandusky, 173rd Gen. Hosp., Longview, Texas; Maj. Maurice C. Archer, Medina, Post Surgeon's Office, Fort Bliss, Texas; Maj. Robert E. Bowman, Cleveland, 79th Med. Bn., Fort Riley, Kan.; Capt. J. M. Canter, Akron, ASF Tng. Center, Camp Ellis, Ill.; Capt. Joseph J. Fink, Cleveland, Regional Hosp., Camp Barkeley, Texas; Lt. Harry A. Haller, Cleveland, U. S. Naval Hosp., Bainbridge, Md.; Capt. John E. Hendricks, Newark, Irradiation Center, AAF Reg. Sta. Hosp., Westover Field, Mass.; Capt. Luther W. High, Millersburg, 312th Med. Bn., 87th Inf., Ft. Jackson, S. C.; Lt. Jos. W. Speier, Wyoming, ASF Reg. Hosp., Pasadena, Calif.; Capt. John M. Thompson, Upper Sandusky, Boca Raton, Fla.

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After 27 months in the South Pacific, Capt. Paul D. Meyer, Euclid, flew home 7,000 miles from the Fiji Islands in 42 flying hours, for a 30-day leave. He left the Fijis on a Tuesday night and arrived in Cleveland on a Thursday afternoon! Capt Meyer has been in the service since January, 1941. He went overseas with the 37th Division in May, 1942, and in Feb., 1943, was transferred to a station hospital, as a chief of the X-ray department.

Capt. John G. Anderson, Lynchburg, is on duty in the office of the Surgeon, Tenth Corps, "somewhere in New Guinea".

* * *

Aboard a ship en route to Australia Dick McGeorge, staff writer for the *Toledo Blade*, ran across a fellow-townsman, Capt. E. A. Gribbin, M.C. Says McGeorge about Capt. Gribbin:

"He would get into our nightly poker sessions and we had a barrel of fun with him.

"All 15 of us, cooped up in a little cabin, broke out with the most damnable heat rash ever to harass a human being. None of us had a cure for it and the line to the dispensary was deck long. So 'Doc' (he was a captain, but 'Doc' to us) would go to his room, get some preparation and attend us. And he had us topside in jig time."

* * *

Immediately after the Battle of Bougainville, Dr. Harold N. Cole, Jr., Cleveland, was promoted from 1st Lieut. to Capt., and received the following citation from the Commanding General for meritorious service from March 20 to March 29, 1944:

"Capt. Cole (then 1st Lt.) assisted in establishing a battalion aid station on Hill 260. This aid station was exposed to heavy enemy intermittent mortar and artillery shelling. During this period, Capt. Cole administered medical treatment to numerous casualties in a highly efficient manner. His personal bravery was an inspiration to all of the men under his command. This devotion to duty on the part of Capt. Cole reflects great credit on himself and is in keeping with the highest standards and traditions of our Army."

* * *

Chief of the general medical service at a general hospital in England, Capt. Robert H. Schoene, Columbus, devotes most of his time to soldiers with chest wounds received on the European continent. According to a press dispatch, Capt. Schoene, who has inaugurated a rehabilitation program for chest cases, reports air evacuation gives men with chest wounds a much better chance of recovery because of their early arrival at hospitals, and that penicillin has proved a valuable aid in the treatment of chest wounds.

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Capt. W. G. Harnett, Fostoria, who has been stationed at a Veteran's Hospital, Montgomery, Ala., has been transferred to a similar hospital at Columbia, S. C.

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Bits of news about Clevelanders: Capt. E. H. Cushing, M.C., U.S.N.R., back in Washington after three months in England, where "is was extraordinarily interesting to have been able to be

in on some of the preliminaries of D-Day" . . . Saw Major Clovis Phillips and lived with Col. Herbert Wright in London . . . Lt. Comdr. R. G. Witwer, flight surgeon on a carrier in the Central Pacific area, had a reunion with Comdr. John Anderson, when the carrier dropper anchor at the latter's station . . . Lt. Col. Howard P. Taylor, with a hospital unit in New Guinea . . . Major John R. Kelker, at the station hospital for an air field in Ft. Myers, Fla. . . . Lt. Col. R. S. Jauch, director of the Laboratory, Brooke General Hospital, Fort Sam Houston, Texas . . . Major E. C. Oberson, chief of surgery with a field hospital in France . . . Capt. H. J. Bavor, battalion surgeon for a field artillery unit somewhere out there in the Pacific "wouldn't trade places with anyone" . . . Capt. H. Roenigk, in India, with the 20th Air Force, and the B-29's, Uncle Sam's superflying fortresses.

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Capt. Cornelius G. Lynch, formerly of Toledo, has been commended by his superior officers for service as an anesthetist on a general surgical team of a field hospital in Italy. He was cited especially for his work with casualties at the Anzio beachhead from Jan. 21 to May 24. Capt. Lynch recently landed with invasion troops in Southern France. Overseas since March, 1943, he was with a number of hospitals in Africa before moving on to Italy.

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Capt. B. M. Brandmiller, Youngstown, having become accustomed to the English pounds and shillings, is now learning about currency in Dutch New Guinea.

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After two years' sea duty in the Mediterranean forward area, Comdr. R. L. Solt, Bucyrus, has returned to the Buckeye state for duty as medical officer for the Navy's V-12 students at Wooster College, Wooster.

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Major Albert B. Sabin, Cincinnati, has been conducting experiments for the Army on dengue and sand-fly fever.

* * *

Comdr. Herman S. Zeve, Youngstown, chief of urology at a Naval hospital in Trinidad, "has kept his good humor through 26 months in the tropics", according to a news story from Port of Spain.

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Recent graduates of the School of Aviation Medicine, Randolph Field, Texas, following completion of the course for aviation medical examiners, include the following Ohio medical officers: Capt. Alfred W. Erb, Piqua; Capt. William M. Garrett, Frankfort; Capt. Gordon H. Hammill, Euclid; Capt. John A. Kramer, Columbus; Capt. Thomas E. Miller, Ironton, Capt. Frank D. Novy, Euclid; 1st Lieut. Samuel M. Schall, Toledo; 1st Lieut. Carl F. Schilling, Cincinnati; Capt. Frederick S. Spiegel, Cincinnati; 1st Lieut. Ralph W. Tapper, Dayton; Capt. Robert E. Tschantz, Hartville.

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In France since the invasion and now in Belgium, as group surgeon with the combat engineers, Major Joseph B. Edelstein, Toledo, reports that he had just received his July and August copies of *The Journal.* Overseas for 33 months, Major Edelstein says: "Good old Ohio sure would look good".

* * *

Major William A. Smith, Mansfield, has been with a station hospital in Africa and Italy for the past 18 months.

* * *

Commanding officer of a station hospital in North Africa, Lt. Col. S. C. Ellis has this to report on his activities, with news about some Ohio colleagues: "Since arriving at this unit, we have moved twice, having been at Bone and at Constantine, Algeria, and now have the hospital divided between two large cities some 30 miles apart. It is the only American hospital within several hundred miles. Keeps me busy commuting. Capt. Al. Greenlee, OSU, '35, from Dennison, was a medical officer with the unit, but recently transferred to the Third Division in France. Major Edward Reno, Canton, is acting commanding officer of a hospital we have relieved here. Have had a varied hospital census, primarily Air Corps at Constantine and now predominantly Navy. Both our hospitals are in nice areas. This latter location overlooks the Mediterranean, giving us a grand scenic view. One would never know a war was going here, except for the ruins of a nearby town our 'forts' razed in April of '43. Hope to see Ohio in not too long a time."

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Major Harold J. Barker, Lorain, was recently awarded the Bronze Star Medal, at Ft. Lewis, Wash., for services contributed as a medical officer with an infantry division in the Southwest Pacific. "The speed and efficiency of medical officers at the camp enabled injured and wounded men to return to duty in a shorter time than was ever before possible", the citation said.

* * *

Lt. Col. Maurice M. Kane, Greenville, recent recipient of the Legion of Merit, rates some sort of accolade for a fine letter from Italy. Here 'tis:

"The box story of yours in the August, 1944, *Journal* sounds to me much like a 'reply by

indorsement hereon' that officers in the service don't like to receive. But since it's unofficial, a similar sort of reply should suffice. It's understood of course that it isn't a directive to reply to and so I'm going to try to bring myself up to date on some neglected correspondence to you.

"I am in command of a medical battalion and like most Co's, I suppose, the best damned outfit in the army. I was really surprised when one of my companies arrived overseas after I had been here for a week or so to find that a newly arrived officer with this company was a Cincinnati physician, Capt. Ralph J. Kessler. Kessler is a splendid chap and has been living up to the ideals and standards of all Ohio physicians. He enjoys the envy of all the officers and men in the battalion in being the only one who can sleep through a shelling or bombing.

"I had the pleasure of working with Lt. Col. Wilkinson's field hospital a while ago and found it to be a "bang-up" organization. Wilkinson is from Van Wert and a former Ohio State man, graduating in the class of '32. I have also met up with two other graduates of Ohio State University, although they are not members of the practicing Ohio profession. One of them, Capt. Lawrence Weinberger, is a classmate of mine in medical school and is doing neurosurgery with an evacuation hospital. The other, Capt. Fox, who is doing orthopedic surgery with an evacuation hospital was in the class of '36.

"I just missed Capt. Ross Zeller in Naples one day at the time he was waiting for a ride back to the States. Ross is a graduate of Ohio State University and we both practiced in Greenville, Ohio. Lt. Col. Arthur Brown, Lt. Col. Walter B. Johnson, Lt. Col. Ralph Shilling, Capt. Benjamin Wills of McArthur, Capt. Ross Zeno of Akron, Capt. Martin Sherman of Dayton and Capt. Harold Lotzoff of Lima all served with me at Ft. Jackson, S. C. back in 1941-42. We have been widely scattered since then of course. Capt. Sidney N. Lord of Somerset was a member of my battalion until recently, but he has since returned to the States. He did a splendid job while he was with me and I regretted having him leave. Major Foster Lowry of Urbana has worked with nearby units on several occasions. Col. F. P. Kintz was my commanding officer at Ft. Jackson but he is now in England. He has been in the regular army since his graduation at Ohio State University in 1932. His home is in Somerset, Ohio.

"The medical profession is doing an excellent job in the service and will continue, as they have in the past, to give their best. The doughboys and line officers are all high in their praise of the high standard of work that the medical profession is doing for them. The physicians whom I have met from Ohio, and reports of others in more remote places, are all recognized for the part they are playing and are right up with the rest of the members of the medical corps in upholding the traditions of the profession.

"I look forward to *The Journal* each month and am rather put out if it doesn't arrive on time. I enjoy "War Notes" particularly, and hope there are enough contributors to the column to keep it going for the duration."

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Lieut. Joseph L. Bilton, East Cleveland, who has been in the Navy over two years, and was overseas for 21 months, recently visited the old home town. He was in action at Bougainville and was in the recent invasion of Guam with the Third Marine Division. His experiences included the fanatical Japanese Banzai attack on a regimental evacuation station which resulted in the death of Lieut. Warren G. Parrish, previously reported in *The Journal.*

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Capt. Stanley E. Turel, Cleveland, reports that after 30 months in the SWPA, he is finally assigned to New Guinea, with a station hospital. Says he has experienced hotter days in Cleveland but not as much rain or mud.

* * *

Wounded on Saipan on August 6, Captain Richard Hotz, Toledo, landed at San Francisco recently after a plane trip from Hawaii, en route to a "mid-west army hospital for treatment". Capt. Hotz was burned seriously on the hands and about the eyes when a shell exploded while he was operating in an advanced hospital.

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Major John E. Martin, Columbus, is assistant division flight surgeon in England with the Eighth Air Force, Third Bombardment Division—a B-17 division which recently received a Presidential citation for the England-Africa shuttle bombing of Regensburg, Germany.

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According to *The Military Surgeon,* a new section has been created in the Planning Division of the Bureau of Medicine and Surgery, U.S. Navy, called the Marine Corps Medical Coordination Branch, to plan, coordinate and make recommendations on medical facilities and services in relation to Marine Corps activities. Captain French R. Moore, M.C., U.S.N., is in charge of this new unit.

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More transfers to new stations within the United States: Lt. Comdr. J. S. McMath, Cincinnati; U. S. Naval Hosp., St. Albans, L. I., New York; Capt. Jonas B. Rayman, Toledo, 238th Gen. Hosp., Camp Barkeley, Texas; Capt. James S. Caldwell, Cincinnati, Madison, Wis.; Major Ivan Smith, Youngstown, Ft. Benj. Harrison, Ind.; Major Floyd A. Potter, Toledo, 492nd. Bomb. Gp., Alamagorda, N. Mexico; Lt. Lincoln C. Dickey, Cleveland, Reg. Hosp., Ft. McClelland, Ala.; Major C. H. Allen, Portsmouth, Memphis, Tenn.; Major Clark Pritchett, Columbus, Sta. Hosp., LAAF, Liberal, Kans.; Major Charles B. Horton, Dayton, Gulf Stream Hosp., Miami Beach, Fla.; Lt. Elliott W. Schilber, Springfield, 303rd FA Bn., Camp Cooke, Calif.; Capt. Joseph G. Rosenbaum, Brecksville, Sta. Hosp., Muskogee, Okla.; Capt. N. A. Brandeberry, Springfield, AAF, Lincoln Nebr.; Lt. Comdr. H. Vern Sharp, Akron, Naval

Hosp., Portsmouth, Va.; Capt. Frank W. Anzinger, Springfield, 555th AAF, BU, Ferrying Div., ATC, Love Field, Dallas, Tex.; Capt. Samuel R. Siegel, Cleveland Heights, Sta. Hosp., AAB, Columbia, S. C.; Capt. J. R. Buchanan, Youngstown, Sta. Hosp., March Field, Calif.; Lt. Comdr. Richard C. Schneble, Dayton, Naval Hosp., Treasure Island, Calif.; Capt. Bernard K. Craw, Toledo, Rome, Ga.; Capt. T. E. Miller, Ironton, Sta. Hosp., Municipal Airport, Memphis, Tenn.; Capt. Raymond Hall, Youngstown, Sta. Hosp., Ft. Knox, Ky.; Capt. J. R. Lutz, North Ridgeville, AAF, Stuttgart, Ark.; Lt. F. M. Krichbaum, M.C., USNR, Canton, Red Cross Blood Donor Center, Baltimore, Md.; Capt. Russell F. Wiggers, Cincinnati, FAAF, Geneva, Nebr.; Capt. J. M. Canter, Akron, 64th Field Hosp., Camp Dix, N. J.; Capt. Harold F. Burkons, Shaker Heights, AAF Convalescent Hosp., Nashville, Tenn.; Major Edw. B. Castle, Cleveland, 196th Gen. Hosp., Camp Grant, Ill.; Capt. Robt. P. Scott, Norwalk, Ashford Gen. Hosp., White Sulphur Springs, W. Va.;; Capt. L. J. Lohr, Dayton, Langley Field, Va.; Capt. S. N. Lord, Somerset, Fletcher Gen. Hosp., Cambridge, Ohio.

* * *

The disease death rate among American soldiers of World War II is the lowest ever recorded for the U. S. Army and only one twentieth as high as that of World War I thanks to an effective program of military preventive medicine, Brig. Gen. James S. Simmons, chief, Preventive Medicine Service, U. S. Army, reported in a nationwide broadcast, August 29, as guest of Schenley Laboratories.

"This is not just a matter of luck", General Simmons said. Owing to the effective program of military preventive medicine carried out by the Medical Department of the Army, thousands of medical officers trained in disease prevention follow the soldier and guard his welfare from the moment of his induction until his return to civilian life, he pointed out. Due to the vaccination of soldiers, he explained, smallpox, the typhoid and paratyphoid fevers, tetanus, yellow fever, plague, cholera and typhus "have been of no importance". Some meningitides, pneumonia and mild influenza have occurred, General Simmons stated, but the death rates have been insignificant.

* * *

Lt. Col. Earl Rosenblum, Steubenville, in England at Hq., 1st Advanced Air Depot Area, reports the following Ohio medical officers associated with him in the Ninth Air Force Service Command: Maj. Samuel H. Eisenberg, Akron, a group surgeon; Maj. George W. Speed, Celina, a group surgeon; Capt. George A. Gressle, Newark, a squadron surgeon and Capt. Edward P. Sparks, Jr., Sidney, a squadron surgeon.

Comments Lt. Col. Rosenblum: "It was through their devotion to duty as well as of the other medical officers in our Command of equal professional calibre, that I received a glowing tribute from my Commanding Officer on the state of health of the Command. I quote some of the more flattering excerpts in the letter of commendation I received on May 14, 1944:

" 'By his exceptional professional skill, leadership, and tact, he has assisted immeasurably in establishing an efficient medical service throughout this Command, which enjoys one of the highest health efficiency ratings in this theatre of operations. Lt. Col. Rosenblum's high professional attainments coupled with sound judgment and initiative have manifested themselves in the superior manner in which he has performed his many important duties. Reflected through the health of the personnel of this Command, Lt. Col. Rosenblum has contributed much to the success of our operation and mission.' "

* * *

On July 27, the Army Medical Department observed the 169th anniversary of the establishment of the first medical service for the American Army. The Medical Department had its inception in the creation by the Continental Congress, July 27, 1775, of a hospital for the American forces shortly after George Washington assumed command in the Revolutionary War.

Among the letters of commendation received by Major General Norman T. Kirk, Surgeon General of the Army, were ones from Lt. General Brehon Somervell, Commanding General of the Army Service Forces and General Henry H. Arnold, Commanding General of the Army Air Forces.

General Somervell wrote:

"The 169th birthday of the Medical Corps is one of which you, your immediate staff and all the officers, nurses and enlisted men of the Corps should be especially proud and I hope that you will accept for them and for yourself my very sincere congratulations on a job most efficiently and bravely done.

"On the combat fronts and at home, you have seen as I have, the superior performance of the Corps and have witnessed not only its splendid role in battle, but also its predominant part in recent medical development and experiment.

"The admirable execution of the mission of the Medical Corps has earned the complete confidence of the country in a function of the Army which is naturally closest to the civilian consciousness.

"We in the Army acknowledge and endorse that confidence, and in addition, add our personal congratulations and praise."

'Particularly valuable'



• Globin Insulin with Zinc is "particularly valuable ...in regulating patients who have a rise of blood sugar after eating only..." reports Herman O. Mosenthal, M. D. (J. A. M. A. 125, 483-488, June 17, 1944.)

Diabetics of this type who are well controlled throughout the twenty-four hours with a single injection of 'Wellcome' Globin Insulin with Zinc, depend for this control on Globin Insulin's rapid onset of action and sustained day-time effect. Its diminishing action at night tends to minimize nocturnal insulin reactions.

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Do You Know - - -

The lead article in the October 7 issue of *The Journal of the American Medical Association*, entitled "Role of the General Practitioner", is the address given by Dr. J. Craig Bowman, Upper Sandusky, as Chairman of the General Practitioner's Section, at the A.M.A. session in Chicago last June.

* * *

Dr. Clyde L. Cummer, Cleveland, a former President of the Ohio State Medical Association and Chairman of the Section on Dermatology and Syphilology of the American Medical Association, has been named to the Executive Committee of the honorary consultants of the Army Medical Library, Washington, D. C.

* * *

James E. Bauman, assistant director and chief of the Legal Division of the State Department of Health, is acting director of the department, pending the appointment of a successor to Dr. R. H. Markwith, whose term expired August 20. With the exception of three years during the Davey administration, Mr. Bauman has been on the staff of the State Health Department continuously since 1892.

* * *

Rt. Rev. Msgr. Maurice F. Griffin, Cleveland, was given an award of merit, presented each year to an outstanding member by the American Hospital Association, at the Association's annual meeting in Cleveland, Oct. 2-6. Msgr. Griffin, senior trustee of the A.H.A., also is treasurer of the Ohio Hospital Association.

* * *

Dr. Thomas H. Sutherland, Marion, was elected to the executive council of the Aero Medical Association at its recent annual meeting in St. Louis. Dr. Sutherland presented a paper on medical safety in aviation at the meeting and was selected a Fellow in Aviation Medicine. He is a medical examiner for the Civil Aeronautics Authority.

* * *

Harvard University has opened the doors of its medical school to women for the first time since the school was founded 162 years ago. Climaxing a long fight, the board of overseers has approved a recommendation of the faculty of the medical school that women be eligible for admission.

* * *

Under Secretary of War Robert Patterson has awarded the Winthrop Chemical Company, Inc., of New York and Rensselaer, N. Y., its third Army and Navy Award for "high achievement in production of war material".

A unique family reunion took place recently at the home of Dr. Edgar Braunlin, Dayton, when he and his four brothers, all of whom are also practicing physicians, gathered together for their annual visit. Attending the gathering were Drs. Carl G. and Walter A., Portsmouth, and Drs. William H. and Robert F. Braunlin, Marion, Indiana. The father of the five physicians, William H. Braunlin, Sr., Portsmouth, also attended.

* * *

At the close of the 100th meeting of the Northwestern Ohio Medical Society, October 3, at Findlay, the following new officers were elected: Dr. Martin W. Diethelm, Toledo, president; Dr. John M. Leahy, Tiffin, vice-president; Dr. Robert J. Semons, Carey, secretary, and Dr. E. L. Brady, Marion, treasurer. Next year's meeting will be held in Toledo.

* * *

Miss Aleeth Willard, formerly associated with the Cleveland Y.W.C.A., has been appointed Director of the Planned Parenthood League of Ohio, with offices at 5 West Broad St., Columbus.

* * *

One of the medals awarded by the Ohioana Library to authors of the six best books of 1943 written by Ohioans, went to Philip D. Jordan, Ph.D., associate professor of history, Miami University, Oxford, and a frequent contributor to the Historian's Notebook of *The Ohio State Medical Journal*. Prof. Jordan received the medal for "The Best Book of the Ohio Scene", entitled "Ohio Comes of Age".

* * *

John D. Goodrich, supervisor of the Claims Section, State Industrial Commission, has resigned after 26 years of service with the Commission to enter the private practice of law in Columbus.

* * *

A Bureau of Industrial Hygiene has been created by the Cleveland City Health Department, with Mr. Herbert G. Dyktor, for more than four years chief engineer of the bureau of industrial hygiene of the Michigan Department of Health, Lansing, as its chief.

* * *

A portrait of the late Dr. Asa Brainard Isham, one of the founders of the new Cincinnati General Hospital, and a former president of the Cincinnati Academy of Medicine, was recently presented to the hospital by the children of Dr. Isham.

Still Making Good ON PRE-WAR PROMISES

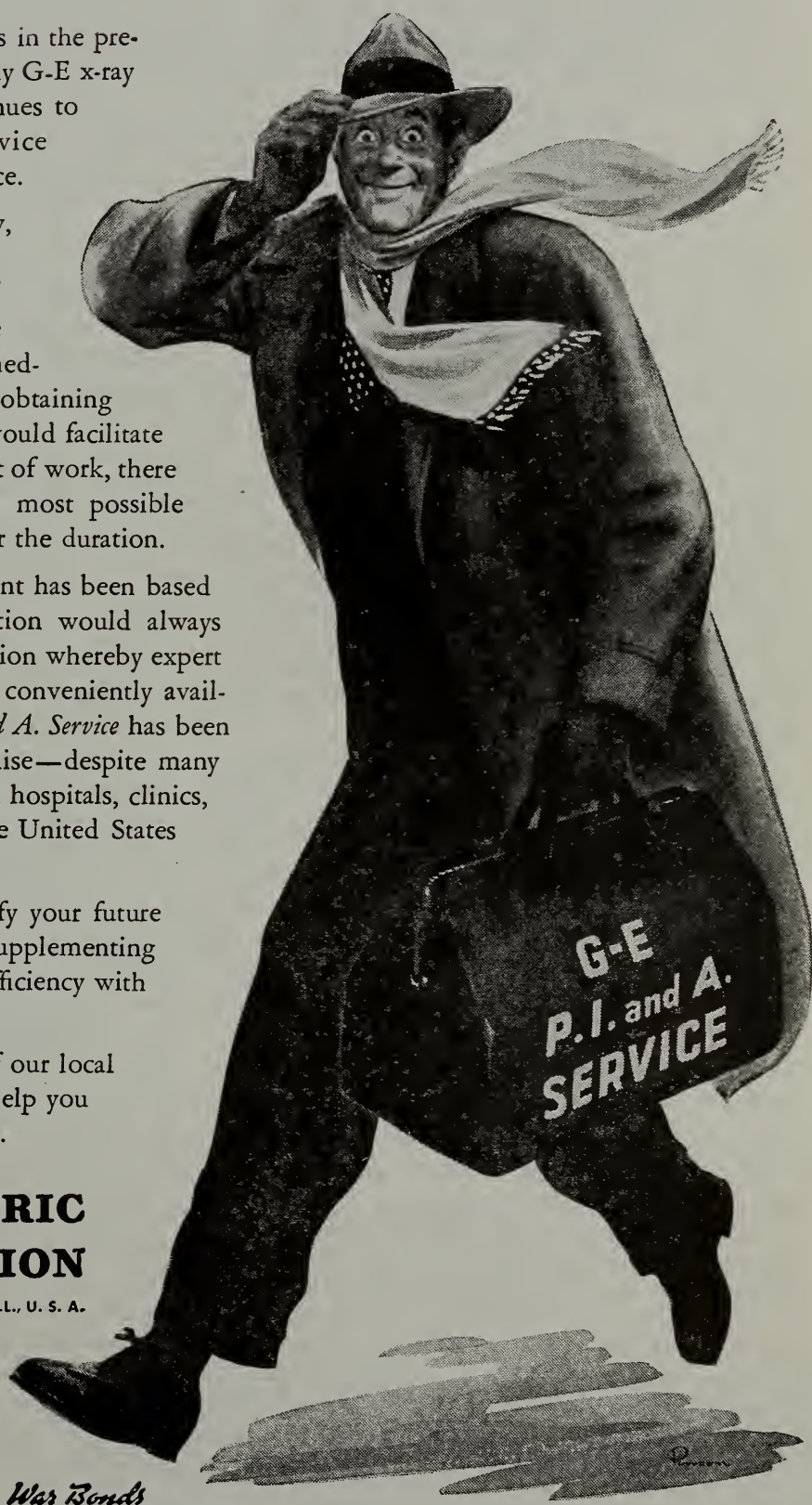
It's calls like this, as frequent today as in the pre-war years, that best serve to explain why G-E x-ray and electromedical equipment continues to efficiently meet the abnormal service demands of wartime civilian practice.

Verily, G-E customers appreciate today, as never before, the value and importance of G.E.'s *Periodic Inspection and Adjustment Service.* For in face of the unprecedented load imposed on the medical home front, and the difficulty of obtaining new and additional equipment that would facilitate the handling of this increased amount of work, there was but one alternative: to get the most possible service out of existing equipment, for the duration.

Many an investment in G-E equipment has been based on the assurance that this organization would always maintain a nationwide field organization whereby expert technical and maintenance service is conveniently available at all times. And G.E.'s *P. I. and A. Service* has been consistently making good that promise—despite many wartime handicaps—in G-E equipped hospitals, clinics, and physician's offices throughout the United States and Canada.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

HOW TO GET MEDICAL RECORD OF DISCHARGED VETERAN

Obviously, those who are being discharged from the armed forces and who are returning to civilian pursuits will at some time or other seek the advice of or treatment from physicians in civilian practice. In handling such cases, the civilian practitioner will be handicapped without a health and medical history of the person while he was in military service. Review of case histories is a fundamental requirement of good practice.

"What can I do in such cases?" the attending physician asks.

Here is the answer:

The War Department has issued a regulation (No. 40-590) authorizing the commanding officer of any hospital where a member of the armed forces may have received treatment to release information from his or her medical record to "registered civilian physicians, on request of the individual or his legal representative, when required in connection with the treatment of the member or former member of the armed forces". It is stipulated that it is expected that the information given will be treated as confidential, as is customary in civilian medical practice.

It probably is safe to assume that the Navy Department and the Veterans' Administration will cooperate in similar fashion.

Therefore, in dealing with ex-service men and women, the attending physician should explain to them the need for this information, how it may be obtained and suggest that the record be secured for his review so he will be better equipped to offer good advice and competent treatment. By doing so the physician will be benefiting the ex-service man or woman as well as himself.

TIME FOR CONGRESS TO DO HOUSECLEANING JOB

It is of interest to learn that the American Academy of Pediatrics is withdrawing its support of the U.S. Children's Bureau. *The Journal of Pediatrics* has announced that "we feel the time has come when the academy and the pediatricians of the United States must withdraw their support from the Children's Bureau and use their influence as a group and as individuals to place all health activities under the Public Health Service". It is reported that the pediatricians have come to the conclusion that the Bureau's policies, especially that with respect to the E.M.I.C. program for families of service men, are an entering wedge for socialized medicine.

The stand of the pediatricians is to be commended. Why they have taken so long to see the light is a mystery. Many of their colleagues in the medical profession have been hep to the Children's Bureau for a long time.

Incidentally, here in Ohio recently a hospital announced that it would no longer accept E.M.I.C. cases because it has been losing money under the fixed rate allowed by the Children's Bureau. A hospital official stated that most hospitals in the larger cities are confronted with the same problem.

Strange to say, a year ago when the Ohio State Medical Association criticized the E.M.I.C. program and refused to officially approve it, the hospitals were awfully quiet, apparently thinking well of the program. Now they are finding out that programs run by Federal edict are bound to become unsatisfactory sooner or later.

The Children's Bureau has for years been a storm center so far as its health and medical activities are concerned. Its policy always has been to reach out for more power and centralization; to encourage more governmental control of medicine. It has never been explained to the satisfaction of many as to just why this particular bureau should be heading up any medical and health activities. It is a part of the Department of Labor and its work should be confined to labor-welfare problems affecting children.

Recently, Director Perkins of the Labor Department sponsored in Congress a proposal for establishment of an industrial hygiene setup to be directed by the Department of Labor at the Federal level and by state labor departments at the state level. Industrial hygiene is a health and medical matter not a labor matter primarily. A good industrial hygiene program is now being carried on by the U. S. Public Health Service in cooperation with state health departments. This should be continued and the Labor Department told to stay in its own backyard.

These developments, among many, indicated that the time is ripe for Congress to do a housecleaning job; time to restore order out of chaos by bringing about a better and more efficient organization of the medical and health activities of the Federal Government.

Admittedly, there are certain health and medical activities which must be carried on by the Federal Government, although some of the pres-

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ent programs might be eliminated without detriment. Additional activities should not be undertaken unless the need for them is proven and it is shown that such activities can not be carried on by the states and local communities or through voluntary agencies.

Nevertheless, those medical and health activities which are the function of the Federal Government should be consolidated and placed into the hands of the U. S. Public Health Service—the logical and best qualified department to handle health and medical programs.

So, sometime when you're talking or writing to your Congressman, you might call this to his attention and indicate that it would be a feather in his cap if he would get behind the Miller Bill (H.R. 4663) which would bring about this consolidation and reorganization.

INDUSTRIAL NURSES URGED TO JOIN NATIONAL SOCIETY

The American Association of Industrial Nurses has opened its drive for new members. This national association was organized in 1942 in recognition of the growth and expansion in the field of industrial nursing. Though the war has brought an extraordinary growth in this area, some of which will be cut as war industries close, industrial nursing is now established as an important and permanent branch of nursing. It demands an organization whose policies are shaped by those who have blazed the trails.

Industrial nursing is an integral part of the growing movement to provide safety and health to our great worker population. This movement, instigated privately by industrial management, and officially by city, state and Federal governments, is a substantial and growing phase in our country's efforts to prevent accident and disease and to promote health.

The AAIN represents nurses in every field of industrial and mercantile establishments. Its governing board is representative of the country as a whole. Its membership requirements are on a par with those of other standard making nursing bodies. It has already made material progress through the appointment of an executive secretary, in appointing counsellors in strategic areas for advising nurses, and in laying the groundwork for university and college courses in industrial nursing. Its expanding action program is centered on a sharing of common problems by all nurses in industry, and in aiding these nurses to broaden their usefulness to society.

The AAIN actively encourages membership in the nursing profession's official bodies, the district, state and national nurses' associations. It also encourages the creation of sections on industrial nursing within these bodies, and it works in close harmony with these and all other agencies concerned with industrial and community health.

In its drive for additional members, the American Association of Industrial Nurses is appealing to management, physicians and safety engineers to assist in spreading information about the association among industrial nurses, according to Mrs. Gladys Dundore, R. N., executive secretary of the association, 54 West 10th Street, New York City.

Ohio physicians are urged to cooperate in the building up of this group which can play such a vital part in industrial health activities. Those who want more complete information should write to Mrs. Dundore.

IS IT AN EFFORT TO CREATE "AN EMERGENCY"?

There is one school of thought among physicians and laymen which believes that refusal of the present Federal administration to intervene to see that an adequate number of premedical students are deferred from military service is a part of a scheme to foist governmental medicine onto the country.

We don't like to believe it—but, could be.

How the plan could work out is described by Frank C. Waldrop, a Washington columnist, whose article was published recently in the *Ohio State Journal*, Columbus.

After analyzing the provisions of the Wagner-Murray-Dingell Bill, Waldrop wrote:

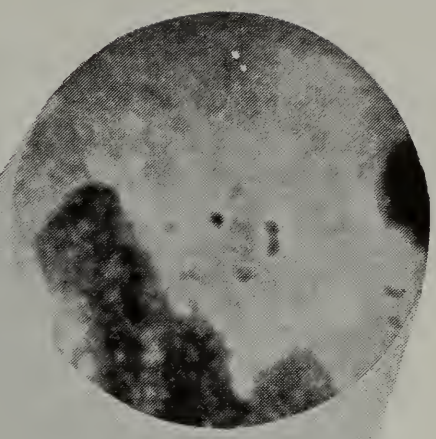
"In brief, the entire basic system of medical practice in America will be governed by the head of one Federal bureau in Washington if the bill goes through. And some astonishingly clever maneuvers have been started to blast it through at the psychologic moment.

"For instance, have you had trouble getting a doctor lately? America is so short on civilian physicians that the House of Delegates of the American Medical Association warns an epidemic of influenza or similar disease would sweep the country in devastating fashion. The doctors just can't get around to their patients now, and in a few years things will be worse, according to A. M. A. Britain, Canada and Russia, looking ahead to the troubles of postwar readjustment are enlarging their systems of medical training now, war or no war.

"But Mr. Roosevelt, in his infinite wisdom, is working in exactly the opposite direction. The overworked older doctors of America are dying daily at the rate of 4,000 a year. They are being replaced at the rate of only 1,500 a year—because F.D.R. has decreed that no premedical students shall be deferred from the draft. By 1948, end of term IV, if any, the effect of this policy would leave the United States with 10,000 fewer doctors than it has today.

"The House of Delegates of the A. M. A. has begged Mr. Roosevelt to think twice about this, and warned him that the result will be a critical loss for the private practice of medicine in the postwar era when care for the veterans will

PNEUMONIA *in* 1944-1945



PNEUMONIA will intrude upon the winter scene as inevitably as the wind, the snow, and the ice. This year as never before, however, the means are at hand for control of this disease by—

Prevention—through public health education programs.

Early Diagnosis—through complete and prompt physical examinations and typing of all suspicious sputa by means of the Neufeld "capsular swelling" reaction.

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in itself be a gigantic assignment and world demand for American medical skill will hit us.

"There just won't be enough young doctors to fill the ranks as the older men die, they show by simple mathematics. But there will be a "crisis", and an "emergency". And then, the political geniuses can spring the Wagner-Murray beartrap at the moment when the country's desperation for medical attention will be at its peak.

"The doctors are up against some of the ablest political propagandists who ever lived. If F. D. R. gets his fourth term, he will socialize them for sure, if he can."

MEDICAL OFFICERS AND MALPRACTICE INSURANCE COVERAGE

A large number of physicians now in military service are carrying professional liability insurance under special "military service policies" offered by various companies in this special coverage field. These policies cover the physician for acts in connection with professional care while in military service. They do not cover him for professional services which he will perform after his discharge from the service.

Therefore, medical officers who carry the limited type of coverage should make it a point to get their policy converted into complete, civilian practice coverage immediately upon returning to civilian life. Better yet, as soon as he knows he will be discharged, a medical officer should get in touch at once with his professional liability insurance company—or some such company, if he has dropped his insurance—and obtain proper coverage so that he will be amply protected when he resumes private practice.

The risk is too great for any physician to neglect taking care of this important matter as promptly as possible.

WHAT'S THE SITUATION IN YOUR TOWN?

Records of the Ohio Industrial Commission show a sharp reduction (13.2 per cent to be exact) in the number of Workmen's Compensation claims filed for the first half of 1944 as compared with the corresponding period in 1943.

There is ample evidence that increased safety efforts in industry have had a lot to do with producing this gratifying condition. In other words, energy and money spent in educational safety work are paying dividends.

Here is something for physicians and others interested in the field of health to think about. If preventive measures will pay such high dividends in the field of safety, they can produce equally large dividends in the field of health. Safety is better than compensation, the safety engineer says. By the same token, prevention is better and cheaper than sickness and medical bills.

It's the duty of the medical profession to put this principle into practice to an even greater degree than heretofore. It's the responsibility of the medical profession to see that local agencies, which are expected to work shoulder to shoulder with physicians in providing preventive services, get a shot in the arm in the form of greater public support, financially and morally.

What is the situation in your town?

Are the citizens of your town awake to the possibilities of an up-and-coming public health department?

Are they willing to give such a department adequate financial support?

Now is a good time to check up on this.

HOSPITAL CONSTRUCTION AND STATE'S RIGHTS

Testifying before a Senate Subcommittee on Wartime Health and Education, Surgeon General Thomas Parran of the U. S. Public Health Service, stated:

"I believe that insofar as practicable all health programs within a state should be concentrated in one state agency. In the event of a Federal aid program for construction (Note: hospitals and medical centers) it should be administered within the state by that agency. Before any construction is started, this state agency should make a thorough study and evaluation of existing facilities, indicating the type and location of new facilities needed and the order of their urgency. No new facilities, either public or private, should be permitted unless they fit into the planned state program."

Before Ohio asks for any handout for new medical and health facilities (that Ohio should do so is extremely doubtful), certainly, needs should be determined by a reliable state agency after a thorough survey. Even if needs are revealed, Ohio should ignore Federal handouts unless it is fully determined that Ohio can not meet its own responsibilities. Ohio should be able to, in our opinion. Remember, state administration is a rare thing in matters where the Federal government puts up the cash. Read the record. Nevertheless, should Ohio look to Washington for help, the logic of Dr. Parran should be the prevailing policy.

EFFECT OF WAGNER BILL ON WORKMEN'S COMPENSATION

A slant on the Wagner-Murray-Dingell Bill which a lot of people must have overlooked in analyzing it is referred to in a recent issue of *Insurance Economics Surveys*, published by the Insurance Economics Society of America. The following is quoted by that publication from an analysis of the bill made by Professor Earl E. Muntz, New York University, for the American Enterprise Association, New York City:

"The Wagner-Murray Bill seeks to remedy the

Penicillin in the chemotherapy of gonorrhea

Supplied in vials containing 100,000 Oxford units

● In 125 out of 129 cases of "sulfonamide resistant" gonorrhea, penicillin achieved freedom from symptoms, and the patients became bacteriologically negative within 9 to 48 hours. "It is not too much to predict that penicillin will prove to be one of the most effective agents in the treatment of a disease that causes great ineffectiveness in the armed forces and in the civilian population." That is the verdict of the Committee on Chemotherapeutic and Other Agents, Division of Medical Sciences, National Research Council (J.A.M.A. *122*:1217—August 28, 1943).



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disability problem by providing for all kinds of disabilities—not only those resulting from non-industrial accidents and non-occupational diseases, but also those arising out of industrial accidents and occupational diseases at present compensated through workmen's compensation acts. Thus it cuts right through the purposes and functions of the state workmen's compensation acts. If these provisions were adopted by Congress they would virtually force the early repeal of all state workmen's compensation laws."

We wonder if those labor officials—incidentally the average laboring man— are aware of this potentiality of the Wagner Bill? Labor is the godfather of workmen's compensation. It has given this subject more consideration and attention in the past than almost any other single program beneficial to working men and women. Labor has had a lot to say—and rightly so—about how workmen's compensation laws are administered. It has been unusually effective because it has been so close to the machinery and personnel which make the state-administered workmen's compensation system tick.

Will labor be in as strong a position to guide the course of programs to compensate the working man for industrial injuries and diseases if the administration is transferred to some Federal bureau? We think not. It may seem to some as if labor would be better off under present conditions, but over the long pull the truism that local officials are more susceptible to public opinion than Federal bureaucrats would apply.

We believe this is a point which the average working man should consider. Discuss it with those patients who realize what the Ohio Workmen's Compensation Law has meant to the working men and women of Ohio. It might prove to be an eye-opener to many of them.

Three More States Approve Voluntary Prepayment Medical Care Plan

Medical societies in Kansas, Missouri and New Hampshire recently approved the establishment of non-profit plans for the voluntary prepayment of medical and surgical bills resulting from hospitalized illness, injury, or maternity care.

This brings to 12 the number of states in which medical prepayment plans are co-ordinated with Blue Cross hospital service plans.

Like Blue Cross, they are non-profit organizations established to furnish maximum benefits to subscribers. States in which medical plans were previously established and co-ordinated with Blue Cross plans are California, Colorado, Michigan, North Carolina, Delaware, New Jersey, Pennsylvania, Massachusetts, and New York.

The Council of Medical Service and Public Relations of the American Medical Association at the recent annual meeting in Chicago went on record as approving "voluntary" prepayment hospital care.

Where state and county medical societies have not formed prepayment medical and surgical plans to meet demands of Blue Cross members for such protection, some Blue Cross plans in co-operation with private insurance companies have made "package plan" health coverage available. In such instances, the employer also may provide his employees with indemnity for death or for loss of time through illness.

American participation in non-profit, voluntary Blue Cross plans for prepaying hospital bills numbered close to 15,000,000 persons as all membership increase records for any six months' period were shattered during the first half of 1944.

Of the 1,754,000 additional Americans who decided to relieve themselves of financial worry when hospitalized, 961,000 enrolled during the second quarter of this year and 793,000 the first quarter.

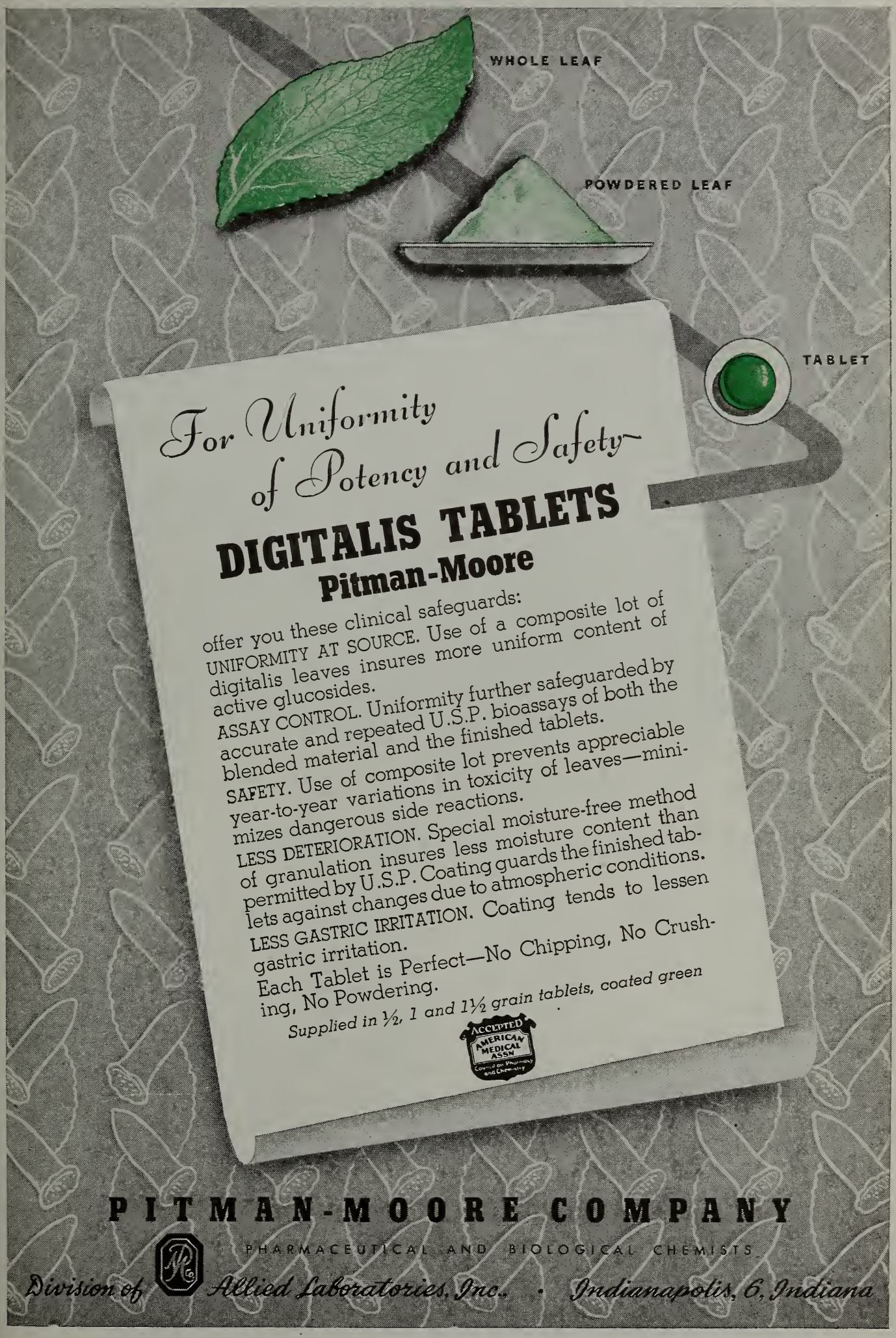
The 14,760,000 men, women, and children who are now protected against the unexpected and unpredictable costs of hospitalized illness or injury are exclusive of 750,000 deferred members serving in the Armed Forces. Although the Army and Navy provide hospitalization for those in active service, many service men continue protecting their family dependents through Blue Cross plans.

Two plans are now well past the one million mark in number of members: New York City (1,606,000) and Michigan (1,142,000). Seven Blue Cross plans have enrolled at present more than 500,000 members: Massachusetts (822,000); Cleveland (801,000); Pittsburgh (708,000); Chicago (655,000); Philadelphia (623,000); New Jersey (617,211); and Minnesota (552,000). An additional 11 plans each now protect 200,000 or more persons.

Family dependents of employed persons comprise 56.5 per cent of those who are Blue Cross protected against hospital bills and employed persons themselves number 43.5 per cent.

Approximately 725,000 hospital bills were paid by Blue Cross plans during the first half of 1944, the cost of which exceeded $35,000,000. Daily admission rate for Blue Cross patients totaled 4,000. Average length of hospital stay amounted to 7.2 days as contrasted with 7.8 days during the same 1943 period.

The recent formation of new hospital care plans in Florida and Indiana makes Blue Cross protection available to the population of 42 states, which contain all but 5,000,000 of the nation's population. Approved plans have also been established in Puerto Rico and seven Canadian provinces.—*Blue Cross Protection*, quarterly publication of the Blue Cross Plans of U. S.


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ASSAY CONTROL. Uniformity further safeguarded by accurate and repeated U.S.P. bioassays of both the blended material and the finished tablets.
SAFETY. Use of composite lot prevents appreciable year-to-year variations in toxicity of leaves—minimizes dangerous side reactions.
LESS DETERIORATION. Special moisture-free method of granulation insures less moisture content than permitted by U.S.P. Coating guards the finished tablets against changes due to atmospheric conditions.
LESS GASTRIC IRRITATION. Coating tends to lessen gastric irritation.
Each Tablet is Perfect—No Chipping, No Crushing, No Powdering.
Supplied in ½, 1 and 1½ grain tablets, coated green
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AMERICAN MEDICAL ASSN
Council on Pharmacy and Chemistry
PITMAN-MOORE COMPANY
PHARMACEUTICAL AND BIOLOGICAL CHEMISTS
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Names of 3,053 Physicians Now On Military Roster of Ohio State Medical Association; Promotions Listed

MILITARY Roster of the Ohio State Medical Association stood at 3,053 as this issue of *The Journal* went to press, including 2,567 Ohio physicians in the Army Medical Corps, 414 in the Navy Medical Corps and 72 in other governmental services. Following are the names of Ohio physicians added to the Military Roster during the past month, those promoted and a breakdown by counties. The star (*) indicates that the man has been in service for some time but that this information has just been received by the Association.

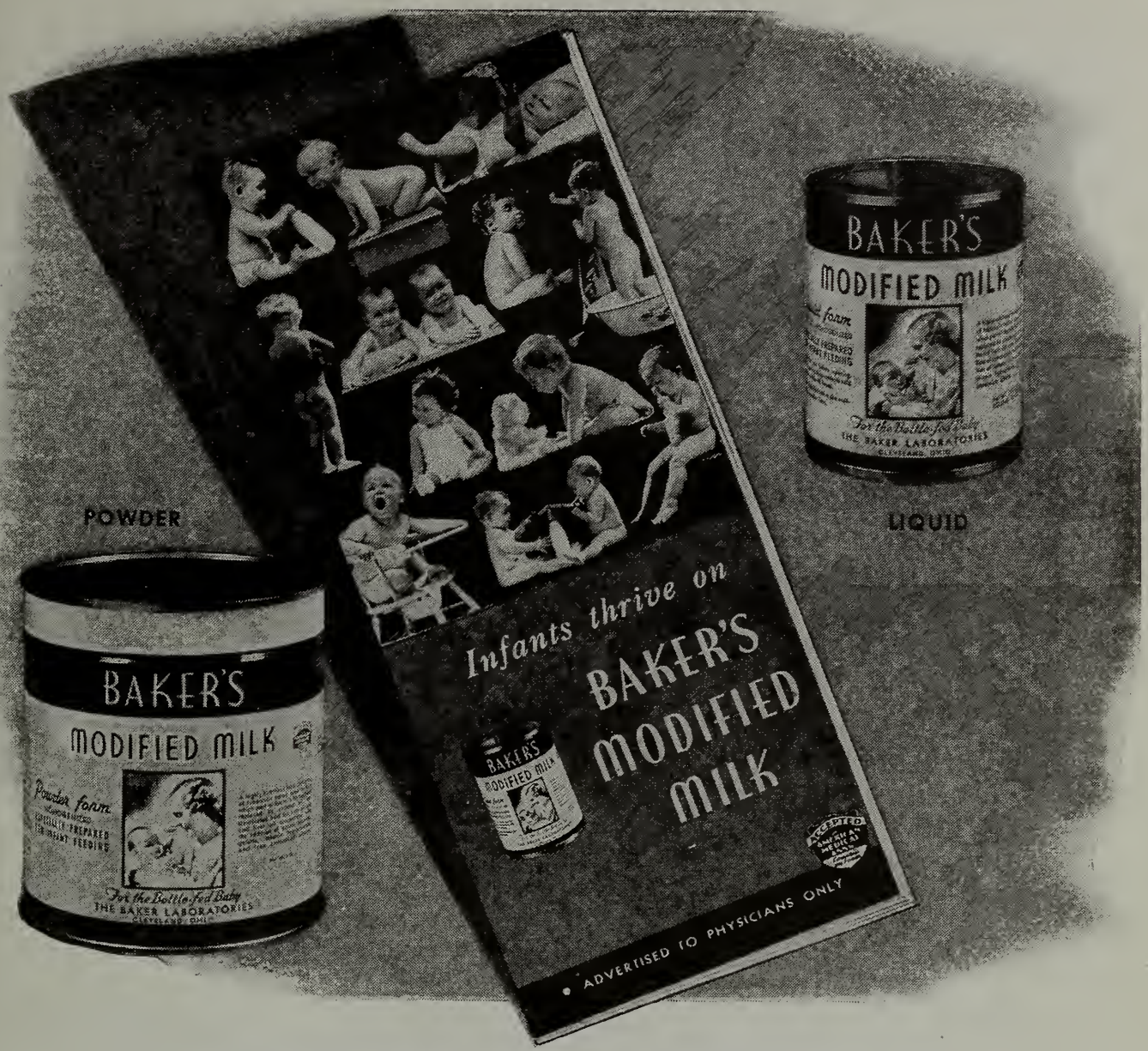
NAMES ADDED TO MILITARY ROSTER

Name	City	Rank
*Abramson, William	Dayton	Major, Vet. Admin.
*Adler, James S.	Canton	1st Lt., U.S.A.
*Ayres, R. W.	Dayton	1st Lt., U.S.A.
Beach, Douglas	Dayton	1st Lt., U.S.A.
Bond, Robert G.	Springfield	1st Lt., U.S.A.
Boyer, Francis C.	Cleveland	Asst. Surg., U.S.P.H.S.
Bremner, Elizabeth A.	Toledo	1st Lt., U.S.A.
Brown, Walter H.	Akron	Lt. (j.g.), U.S.N.
Brown, Woodrow E.	Toledo	Lt. (j.g.), U.S.N.
Buente, Louis C.	Cincinnati	1st Lt., U.S.A.
*Bullock, Richard E.	Toledo	1st Lt., U.S.A.
Buser, Julian Wm.	Cincinnati	1st Lt., U.S.A.
Cahill, Robert Charles	Columbus	1st Lt., U.S.A.
Chaney, Milford S.	Dayton	1st Lt., U.S.A.
Cheek, Paul E.	Akron	Lt. (j.g.) U.S.N.
Claybourn, Norman Leigh	Akron	1st Lt., U.S.A.
*D'Amore, A. R.	Youngstown	1st Lt., U.S.A.
*Debski, Stanley F.	Dayton	1st Lt., U.S.A.
*Detesco, Alfred A.	Youngstown	Lt. (j.g.), U.S.N.
DeVaux, William D.	Cincinnati	1st Lt., U.S.A.
Dickerhoof, Gilbert Ray	Lima	1st Lt., U.S.A.
*Ensign, William G.	Cleveland	1st Lt., U.S.A.
Federer, Harold W.	Columbus	1st Lt., U.S.A.
Fox, Robert T.	Dayton	1st Lt., U.S.A.
Freeman, Edson A., Jr.	Akron	1st Lt., U.S.A.
Freeman, Florian G.	Akron	Lt. (j.g.), U.S.N.
Fries, Wm. H.	Dayton	1st Lt., U.S.A.
*Gambrel, Francis J.	Youngstown	1st Lt., U.S.A.
*Gelbman, Frank	Youngstown	1st Lt., U.S.A.
*George, Walter L.	Cleveland	Capt., U.S.A.
Geyer, Joseph Herbert	Cleveland	1st Lt., U.S.A.
*Gibbons, Robert F.	Toledo	1st Lt., U.S.A.
*Gotz, Alexander	Toledo	Capt., U.S.A.
Haddock, James Nelson	Toledo	1st Lt., U.S.A.
*Hall, Robert W.	Akron	1st Lt., U.S.A.
*Harris, Jack L.	Dayton	1st Lt., U.S.A.
Hattendorf, O. Warren	Cincinnati	1st Lt., U.S.A.
*Hayes, William	Akron	1st Lt., U.S.A.
*Herrick, Richard B.	Akron	1st Lt., U.S.A.
Hulit, Bob Eugene	Akron	Lt. (j.g.), U.S.N.
*Isley Homer E.	Toledo	1st Lt., U.S.A.
Janis, Edward C.	Cleveland	1st Lt., U.S.A.
*Jenike, Thomas S.	Cincinnati	Lt., U.S.N.
*Johnson, Nicholas J.	Youngstown	1st Lt., U.S.A.
*Jones, Charles F., Jr.	Toledo	1st Lt., U.S.A.
*Jones, Merrill F.	Canton	1st Lt., U.S.A.
Joyce, Milton H.	Cleveland	1st Lt., U.S.A.
*Kayser, Frederick Wm.	Toledo	1st Lt., U.S.A.
Kellogg, Ralph H.	Cleveland	Lt. (j.g.), U.S.N.
*Koller, William S.	Dayton	1st Lt., U.S.A.
*Kreuter, George Carlton	Toledo	1st Lt., U.S.A.
*LaFollette, Paul S.	Canton	Lt. (j.g.), U.S.N.
*Linz, Vincent H.	Cincinnati	1st Lt., U.S.A.
McAvoy, Harry D.	Toledo	1st Lt., U.S.A.
*McCulloch, Charles	Akron	1st Lt., U.S.A.
*Mesaros, Paul	Youngstown	1st Lt., U.S.A.
*Michals, Arnold A.	Akron	1st Lt., U.S.A.
*Millonig, Arthur F.	Dayton	1st Lt., U.S.A.
*Moran, Joseph P.	Toledo	1st Lt., U.S.A.
Niesen, Edmond H.	Cincinnati	1st Lt., U.S.A.
*Oliphant, F. W.	Toledo	Capt., U.S.A.
Oyer, Robert S.	Lima	1st Lt., U.S.A.
*Pfaadt, Wm. E.	Cambridge	1st Lt., U.S.A.
*Riemenschneider, Edwin A.	Cleveland	Lt., U.S.N.
Ritchey, Arthur F.	Cincinnati	1st Lt., U.S.A.
*Roncke, George Joseph	Toledo	1st Lt., U.S.A.
Rose, Edgar K.	Akron	1st Lt., U.S.A.
Schriver, Howard M.	Cincinnati	Lt. (j.g.), U.S.N.
Shively, Franklin L., Jr.	Cleveland	1st Lt., U.S.A.
Sieling, Walter H., Jr.	Toledo	1st Lt., U.S.A.
Simoson, Leo H.	Cleveland	1st Lt., U.S.A.
*Skaryd, William S.	Akron	1st Lt., U.S.A.
Starcke, Sewell K.	Cleveland	Lt. (j.g.), U.S.N.
Sternfeld, Ernst	Toledo	1st Lt., U.S.N.
Superfisky, Paul P.	Cleveland	1st Lt., U.S.A.
Tessier, Roland N.	Cincinnati	1st Lt., U.S.A.
Townsend, Milford W.	Akron	1st Lt., U.S.A.
Tyler, John L.	Cincinnati	1st Lt., U.S.A.
*Vinzant, Lawrence E.	Akron	Lt. (j.g.), U.S.N.
*Waag, Donald Alfred	Dayton	1st Lt., U.S.A.
Whitaker, Jack L.	Cleveland	1st Lt., U.S.A.
White, Albert Evans	Cleveland	1st Lt., U.S.A.
*Wickter, Ralph A.	Toledo	1st Lt., U.S.A.
*Wiley, Stuart Paul	Akron	Lt. (j.g.), U.S.N.
*Wilkerson, Joseph L.	Toledo	Lt. (j.g.), U.S.N.
*Witker, Jack Carlton	Toledo	1st Lt., U.S.A.
*Young, Victor H.	Toledo	1st Lt., U.S.A.

WIN PROMOTIONS

Name	City	Rank
Adolph, Paul E.	Bellevue	Major, U.S.A.
Bilton, J. L.	Cleveland	Lt., U.S.N.
Blackledge, Ord C.	Cleveland	Major, U.S.A.
Bone, James R.	Cincinnati	Capt., U.S.A.
Cole, Harold N., Jr.	Shaker Hgts.	Capt., U.S.A.
Erb, Alfred W.	Piqua	Capt., U.S.A.
Flagge, Albert E.	Cincinnati	Capt., U.S.A.
Forrester, Jos. Chas.	Columbus	Major, U.S.A.
Gendelman, Samuel	Manchester	Capt., U.S.A.
Graf, Douglas P.	Cincinnati	Capt., U.S.A.
Haines, Robert A.	Cincinnati	Capt., U.S.A.
Hansen, Paul G.	Warrensville	Col., U.S.A.
Hirsheimer, Albert	Dayton	Major, U.S.A.
Klopfenstein, A. R.	Toledo	Comdr., U.S.N.
Krasne, Saul I.	Wickliffe	Capt., U.S.A.
Levine, Milton	New Boston	Capt., U.S.A.
Lutz, John R.	N. Ridgeville	Capt., U.S.A.
Lynch, Cornelius G.	Toledo	Capt., U.S.A.
Marinelli, Adolphus C.	Youngstown	Lt. Col., U.S.A.
Martin, John E.	Bexley	Major, U.S.A.
Maxwell, Joseph A.	Montpelier	Lt., U.S.N.
McCollam, Ben R.	Toledo	Lt., U.S.N.
Miller, Thomas E.	Ironton	Capt., U.S.A.
Newman, Allen P.	Toledo	Capt., U.S.A.
Pagano, James J.	Canton	Capt., U.S.A.
Patterson, Owen F.	Holmesville	Capt., U.S.A.

(Continued on page 1090)



INFORMATION
To Help You Simplify Infant Feeding Problems

COLIC—constipation—loose stools—regurgitation—failure to gain—and similar difficulties are frequently caused by improper diet.

Baker's Modified Milk is prescribed by physicians because it is a food which closely conforms to human milk and helps to prevent dietary difficulties. With Baker's, infant feeding problems are also simplified since the same food is suitable from birth throughout the entire bottle feeding period, exactly as in the feeding of human milk.

The advantages and use of Baker's Modified Milk are completely described, with feeding directions, in a new folder which you will want to have available.

Copies of this informative folder will be sent to physicians and hospitals on request.

★ ★ ★

Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B_1 and D. Not less than 400 units of vitamin D per quart.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

THE BAKER LABORATORIES
CLEVELAND, OHIO
West Coast Office: 1250 Sansome Street, San Francisco, California

Name	City	Rank
Petcoff, B. E.	Toledo	Major, U.S.A.
Petznick, Geo. W.	Shaker Heights	Major, U.S.A.
Ringer, Robert A.	Cambridge	Capt., U.S.A.
Rodabaugh, Franklin D.	Toledo	Capt., U.S.A.
Sanders, Edw. W.	Bellevue	Capt., U.S.A.
Scherer, John R.	Portsmouth	Capt., U.S.A.
Smith, Wm. A.	Mansfield	Major, U.S.A.
Spiegel, Frederick S.	Cincinnati	Capt., U.S.A.
Stanton, Eugene J.	Elyria	Lt. Col., U.S.A.
Steinberg, Abraham H.	Toledo	Capt., U.S.A.
Steuer, Leonard G.	Cleveland	Lt. Col., U.S.A.
Steyer, Clement E.	Lakewood	Major, U.S.A.
Tepe, Wm. R.	Norwood	Capt., U.S.A.
Vecchio, Frank	Cleveland	Major, U.S.A.
Wartman, W. B.	Cleveland	Lt. Col., U.S.A.
Weiser, Richard W.	Cincinnati	Major, U.S.A.
Wylie, Burdette	Cleveland	Major, U.S.A.
Zollett, Philip B.	Cleveland	Capt., U.S.A.
Zwick, Louis S.	Wadsworth	Major, U.S.A.

TABULATION BY COUNTIES

Adams	2	Guernsey	7	Muskingum	9
Allen	39	Hamilton	488	Noble	1
Ashland	12	Hancock	13	Ottawa	9
Ashtabula	18	Hardin	7	Paulding	2
Athens	11	Harrison	4	Perry	4
Auglaize	6	Henry	3	Pickaway	5
Belmont	14	Highland	8	Pike	2
Brown	4	Hocking	4	Portage	2
Butler	30	Holmes	2	Preble	7
Carroll	1	Huron	16	Putnam	6
Champaign	9	Jackson	1	Richland	38
Clark	38	Jefferson	29	Ross	24
Clermont	9	Knox	11	Sandusky	12
Clinton	8	Lake	18	Scioto	20
Columbiana	11	Lawrence	6	Seneca	12
Coshocton	4	Licking	17	Shelby	7
Crawford	9	Logan	8	Stark	103
Cuyahoga	756	Lorain	40	Summit	167
Darke	6	Lucas	179	Trumbull	27
Defiance	4	Madison	6	Tuscarawas	20
Delaware	7	Mahoning	134	Union	2
Erie	10	Marion	16	Van Wert	9
Fairfield	9	Medina	13	Vinton	2
Fayette	2	Meigs	3	Warren	4
Franklin	244	Mercer	6	Washington	8
Fulton	6	Miami	15	Wayne	14
Gallia	5	Monroe	1	Williams	8
Geauga	4	Montgomery	164	Wood	19
Greene	7	Morgan	3	Wyandot	3
Total					3053

Dr. Sollmann Honored at Dinner

On September 25, a testimonial dinner was given by the Faculty and Alumni of the School of Medicine of Western Reserve University in honor of Dr. Torald H. Sollmann, dean emeritus and professor emeritus of pharmacology and materia medica.

Dr. Marion A. Blackenhorn, professor of medicine, University of Cincinnati College of Medicine, represented the alumni in his speech entitled "Our Old Friend Solly". Representing the faculty, Dr. Carl J. Wiggers, professor of physiology, School of Medicine, Western Reserve University, spoke about our "Professor and Dean".

Dr. Sollmann was then presented with a silver engraved plaque from the faculty and alumni in recognition of his distinguished service. Dr. Winfred C. Leutner, President of Western Reserve University, served as toastmaster.

Bowersville—Dr. C. E. Ream has just completed 50 years in the general practice of medicine in Greene County.

Policy on Future Activities Is Issued by Procurement and Assignment Service

Paul V. McNutt, chairman of the War Manpower Commission, issued the following statement on the policy adopted by the directing board of the Procurement and Assignment Service of the War Manpower Commission at a meeting on September 23:

"The war is not yet over and we must continue our efforts to keep the armed services supplied with a sufficient number of doctors, dentists and nurses to meet the critical needs of this period of the war and also fulfill our obligation to the home front.

"In common with the other divisions of the War Manpower Commission, however, the Procurement and Assignment Service is cooperating with those charged with the responsibility for developing demobilization plans. In view of the information collected incident to the mobilization of our medical resources for war, this office can perform many useful services in connection with these demobilization plans in the interest of the members of the professions now in service. The War Manpower Commission wishes to be of whatever service possible but, in common with all war agencies, has no interest in perpetuating its contrals beyond the period necessary".

In order that the point of view of the directing board of the Procurement and Assignment Service may be understood by the doctors, dentists, veterinarians, sanitary engineers and nurses, the following statement of policy was adopted at its meeting on September 23:

1. The Procurement and Assignment Service is an organization which was created at the request of these professions to meet a war problem, and in meeting its responsibilities this service has had the support of these professions.

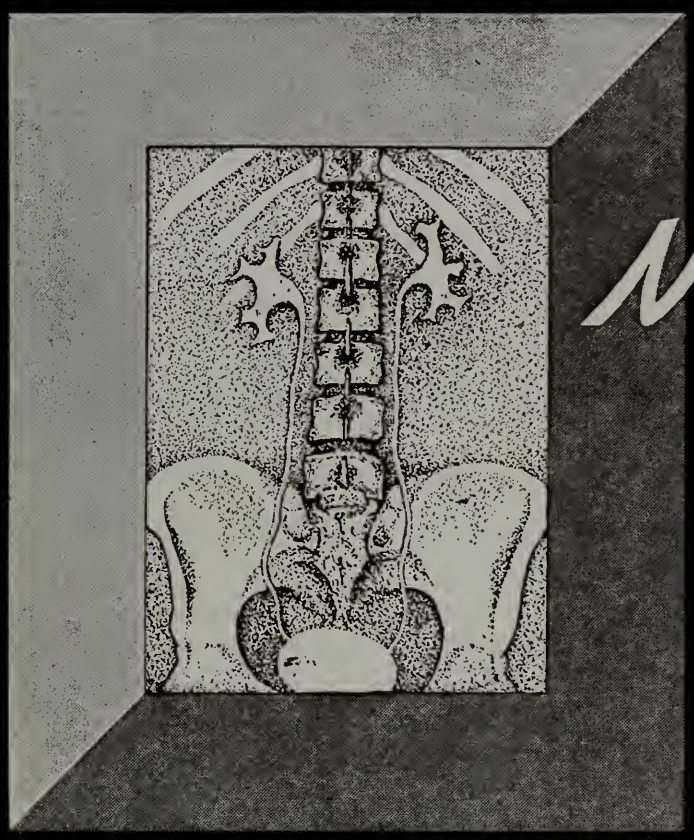
2. As a war agency this service is discharging and will continue to discharge its obligations until the end of the war. It will cooperate with the agencies concerned with the effective utilization of the individual members of these professions who are demobilized before the end of the war.

3. In the directive under which it was created, the responsibilities of the Procurement and Assignment Service did not extend beyond the duration of the war.

4. Therefore, it does not contemplate dealing with peacetime demobilization but will continue its activities, including cooperation with agencies working on demobilization plans, so long as the war continues.

The members of the directing board are Drs. Frank H. Lahey, chairman, Harvey B. Stone, vice-chairman, C. Willard Camalier, Jr., Harold S. Diehl, James E. Paullin and Abel Wolman.

BEING a stable, organic iodide, NEO-IOPAX may be used with greater safety than other types of iodine preparations in all age groups. Because of its optimal iodine content and its rapid excretion in high concentration, diagnostic films may be obtained within five minutes after injection. NEO-IOPAX is usually well tolerated both by intravenous injection and retrograde administration.



Neo-Iopax

IN INTRAVENOUS UROGRAPHY

IN RETROGRADE PYELOGRAPHY

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

SOLUTION NEO-IOPAX: Crystal-clear solution of disodium *N*-methyl-3, 5-diiodo-cheli-damate in 50% and 75% concentration.

COMBINATION economy package of 50% solution containing both 20 cc. ampules and 10 cc. ampules: also 75% solution in ampules of 20 cc. or 10 cc.

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FOR VICTORY AND AFTER: BUY WAR BONDS

State Medical Board Examines Large Group At Fall Meeting in Columbus, Sept. 26-29

LICENSES to practice medicine and surgery in Ohio were sought by 256 medical school graduates at the Fall examinations of the State Medical Board, Sept. 26-29, at Columbus.

Eleven applicants were examined in osteopathic medicine and surgery. In addition, 87 osteopaths, previously licensed in Ohio, sought licensure in accordance with the provisions of Sub. H. B. 112, which became effective July 30, 1943. Examinations for certificates of limited practice were taken by 8 chiropractors, 17 mechano-therapists, 4 chiropodists, 15 masseurs, and 5 cosmetic-therapists.

Results of the examinations will be announced at the meeting of the Board to be held in Columbus, Nov. 13-14.

Following are the questions asked those who were examined for licenses to practice medicine and surgery:

ANATOMY

1. Explain the anatomy of referred pain from the diaphragm, the gall bladder and the ureter.
2. Discuss the anatomy of the afferent and efferent innervation of the heart.
3. Describe the anatomy which may be seen on anoscopic and proctoscopic examination.
4. Discuss the structures passing from pelvis through the greater sciatic foramen. Give their relative positions, their course and distribution of each.
5. Differentiate between the vertebrae of the various sections of the spinal column. What movements are possible in the various sections?

BACTERIOLOGY

1. Mention two malaria parasites found in this country and give the life cycle of each.
2. Give the life cycle of trichinella spiralis; discuss the method of infecting man and the laboratory diagnosis.
3. What laboratory tests should be made of donor and patient before a blood transfusion? Describe tests briefly and discuss reasons for electing the use of (a) whole blood, and (b) blood plasma.
4. What organism causes typhus fever? How is it conveyed to man and hence what steps are indicated in the event of a threatening epidemic?
5. Discuss hook-worm disease; describe organism, how obtained for diagnosis, method of transmission and the steps indicated in an infected community.

CHEMISTRY

1. What is the characteristic composition of an amino-acid and how does this composition determine its unique chemical properties?
2. What is a carbohydrate chemically?
3. What is the significance of creatin and creatinin excretion?
4. Describe the P. S. P. excretion test.
5. What is the normal range of the icteric index?

DIAGNOSIS

1. Name three conditions that may occur in the mediastinum and at least three symptoms of each condition.
2. Name three conditions that may cause free fluid in the abdominal cavity and give physical findings of free fluid in the abdominal cavity.
3. Give symptoms and physical findings in a moderate trichinosis invasion of the body.
4. Give laboratory and symptomatic findings in malaria, undulant fever, and acute rheumatic fever.
5. Where may echinococcus cysts occur and give symptoms in one location.
6. What is a dermoid cyst and where may we find them?
7. Give symptoms of an acute osteomyelitis.
8. Give symptoms of acute thyroiditis.
9. Give signs and symptoms of subacute bacterial endocarditis.
10. Give two findings in myeloma and myelitis.

MATERIA MEDICA AND THERAPEUTICS

1. Give the preparations and dose, therapeutics and toxicology of gold.
2. Aside from its use in diabetes mellitus, what are the other uses of insulin? Discuss its action in each instance.
3. Name the mercurial diuretics. Give mode of action. Discuss toxicology.
4. What therapeutic agents are used to produce immunity in the human body? How is each administered?
5. Compare the effects on the human eye of a 1% aqueous solution of atropine sulphate and 2% aqueous solution of cocaine hydrochloride.
6. Discuss the physiologic action and therapeutic uses of scopolamine; of prostigmine.
7. Name two drugs indicated for use for each of the following: syphillis; pneumococcus infection; streptococcus hemolyticus infection; malaria; subacute bacterial endocarditis.
8. What therapeutic measures are indicated in: naupathia (seasickness); loss of consciousness due to high altitude; contact with phosgene; mosquito bites; pernio (childblain).
9. How do you determine when asphyxia is due to carbon monoxide gas? What is the treatment?
10. What is the effect of the nitrites on the alimentary tract?

MATERIA MEDICA AND THERAPEUTICS
(Homeopathic)

1. Compare the respiratory symptoms of (a) arsenicum, (b) causticum, (c) ipecacuanha, (d) hepar sulphuris calcareum, (e) spongia.
2. Give the key-note symptoms of three remedies to be used in mumps.
3. Compare the use in measles of (a) aconite napellus, (b) euphrasia, (c) tartar emetic, (d) pulsatilla nigricans, (e) veratrum viride.
4. Give the symptomatology that would indicate your use of three remedies in pleurisy.
5. Compare (a) cactus grandifloris, (b) crataegus, (c) spigelia in heart conditions.
6. Give the symptoms that would indicate the use of rhus toxicodendron in typhoid fever.
7. Compare three remedies for use in hemorrhagic conditions.
8. Compare (a) bryonia alba, (b) gelsemium, (c) eupatorium perfoliatum, (d) ferrum phosphoricum in acute influenza.
9. Give the indications for the use of chelidonium in disease of the liver.
10. Give indications for each of two remedies for use in chronic sinusitis.

OBSTETRICS AND GYNECOLOGY

1. How would you diagnose hydramnion at the beginning of the ninth month of pregnancy? Give treatment.
2. What role does the Rh factor play in obstetrics?
3. Discuss duration of labor as to advantages and disadvantages to mother and child.
4. What are the causes and treatment of sterility?
5. What is meant by habitual abortion? Discuss as to etiology and treatment.

PATHOLOGY

1. Describe the pathology, gross and microscopic, of carcinoma of the gastric pylorus and discuss the resulting disturbances of health and function.
2. Discuss tuberculosis peritonitis; etiology, pathology and clinical progress.
3. Name a common benign tumor of the uterus; describe its histologic structure and explain the relation to the clinical symptoms.
4. A patient dies with general anasarca. In what three areas or structures in the body might you find the causative pathology? Give explanation of the relation of the pathology to the anasarca.
5. Discuss the pathology which may cause dysmennorrhea.
6. Name the body areas most commonly affected by syphillis in (a) the primary, (b) the secondary, and (c) the tertiary stages.
7. Name three conditions associated with chronic enlargement of the spleen with pathologic changes in each.
8. A patient is brought to the hospital in dying condition with an indefinite clinical history. Give autopsy findings indicating cause of death if from (a) corrosive poisoning; (b) morphine; (c) cerebral hemorrhage; (d) mercurial poisoning and (e) carbon monoxide.
9. Discuss the pathology of chronic glomerulonephritis, (a) in the kidney, and (b) secondary changes in other body areas.
10. Discuss the probable pathology in an instance of spontaneous pneumothorax.

PHYSIOLOGY

1. **(10 points).** Define (a) acetonuria; (b) basophiles; (c) chromatolysis; (d) genes; (e) haustral churning; (f)



THE story of Penicillin is a shining example of international cooperation for the good of mankind.

From Fleming's observations in 1929, through the pioneer work of Florey's research team, to the large-scale production of Penicillin by the American Pharmaceutical Industry, the story is one of unprecedented teamwork which has extended far beyond national boundaries.

Such cordial cooperation between individual British and American scientists, the Rockefeller Foundation, the National Research Council, the U. S. Department of Agriculture, the War Production Board, the American Pharmaceutical Industry, and the Medical Services of the British and American Armed Forces, has never before been equaled.

Cheplin Biological Laboratories, Inc. are proud to be a member of this international team.

"ACCEPTED STANDARDS AT AN ACCEPTABLE COST"

CHEPLIN BIOLOGICAL LABORATORIES, INC.

(Unit of Bristol-Myers Company)

Syracuse, New York

inorganic food; (g) micturition; (h) oxyhemoglobin; (i) thrombin; (j) neutrophiles.

2. (30 Points). Discuss joints or articulations of the body as to types and functions with examples of each. (Not over six hundred words.)

3. (10 Points). Discuss the physiology of smelling.

4. (10 Points). Discuss low blood-pressure, its physiology with causes, dangers and what it indicates.

5. (20 Points). Discuss blood "donation", its immediate and late effects on the human, its dangers and the frequency permissible.

6. (10 Points). Describe the function of the vaso-motor system with factors affecting the same. Give five important examples of depressor reflexes on the circulation.

7. (10 Points). Discuss briefly the mechanism of deranged mineral physiology in pernicious vomiting.

PRACTICE

1. Give etiology, symptoms, laboratory findings and treatment of acute catarrhal jaundice. How would you distinguish it from two other conditions associated with jaundice?

2. What characteristic lesion may be found in the mouth in (a) scarlet fever, (b) measles, (c) diphtheria, (d) chicken-pox, and (e) small-pox?

3. Indicate the types of infections calling for the use of sulfanilamide; give dosage and what indications may arise to discontinue the drug?

4. What is meant by virus pneumonia? Give symptoms and how would you distinguish it from pneumococcal pneumonia? Outline the treatment.

5. Give the treatment of a case of congestive heart failure with extensive edema, orthopnea, diminished urinary out-put with albuminuria, intermittent pulse, cough and blood stained sputum.

PREVENTIVE MEDICINE

1. Name three diseases that may be carried by milk and outline preventive measures to avoid such occurrences.

2. Give complete procedures to be employed in an outbreak of scarlet fever in a community of about five thousand inhabitants.

3. (a) What are the legal medical requirements in Ohio for those anticipating marriage? (b) Name diseases that legally should be reported to the Health Department in Ohio.

4. Discuss undulant fever as to causes, mode of transmission, and measures to be instituted to control the disease.

5. What are the causes, mode of transmission, and means of avoiding pellagra?

SURGERY

1. Give the surgical management of Compound Comminuted fractures of both the tibia and fibula at the middle third of the leg.

2. Enumerate the most common causes of acute intestinal obstruction. Give the symptoms and indicate the treatment without going into detail.

3. Discuss wounds of the buttocks as seen in modern warfare. Give treatment.

4. Discuss the diagnostic and therapeutic indications for spinal puncture in head injuries.

5. Upon what symptoms and physical findings would you make a diagnosis of "rupture of the male urethra"? Describe methods of examinations and methods of repair.

SPECIALTIES

1. Give etiology, symptoms and treatment of erysipelas.

2. Define dacryocystitis and give treatment.

3. Give the advantages and the disadvantages of ether as a general anesthetic.

4. Describe catarrhal laryngitis and give treatment.

5. What is a mydriatic? Name three.

Guest speakers on the program of the 79th Annual Session of the Michigan State Medical Society, Sept. 27-29, at Grand Rapids, included the following Ohioans: Dr. Tom D. Spies, Cincinnati, "Vitamins and the Practice of Medicine"; Dr. A. D. Ruedemann, Cleveland, "The Protruding Eye"; Dr. Max M. Zinninger, Cincinnati, "Gall Bladder"; Dr. A. A. Applebaum, Toledo, "Primary Atypical Pneumonia"; Major Frank H. Mayfield, M.C., formerly of Cincinnati, now chief of the neurological section, Percy Jones General Hospital, Battle Creek, Mich., "Peripheral Nerve Injuries".

Council on Physical Therapy Becomes Council on Physical Medicine

The Council on Physical Therapy of the American Medical Association has become the Council on Physical Medicine. This is in accordance with an action by the Association's House of Delegates at the recent annual session in Chicago. Discussing the change, *The Journal of the A.M.A.* said:

"The designation 'physical medicine' is a more inclusive term. Physical agents are used not only for therapy but also for diagnosis. Hospital departments of physical medicine, when they employ electric tests for reaction of degeneration or perform such tests as the cold pressor test, are employing physical agents not for therapy but for diagnosis.

"The Council has for some time interested itself in certain phases of occupational therapy, which is a branch of the broad field of physical medicine. The Council was informed that the American Occupational Therapy Association was anxious to have the Council give more attention to occupational therapy. Discussions between representatives of the Council and the American Occupational Therapy Association indicated that the association would welcome the inclusion of occupational therapy under a Council on Physical Medicine.

"Under the following definition for physical medicine, the entire field can be covered by a Council on Physical Medicine: Physical medicine includes the employment of the physical and other effective properties of light, heat, cold, water, electricity, massage, manipulation, exercise and mechanical devices for physical and occupational therapy in the diagnosis and treatment of disease. The Council believed that it would be wise to appoint a special subcommittee of five physicians interested in occupational therapy, who could help to bring this phase of therapy more fully under direct medical supervision.

"Finally there is definite precedent for the use of the term 'physical medicine' which has long been considered the most acceptable term by our British colleagues. The Conjoint Board of the Royal College of Physicians and the Royal College of Surgeons has just instituted a diploma in physical medicine.

"With its new name the Council on Physical Medicine will continue to function as it has always functioned but will devote additional attention to problems of occupational therapy."

Dr. Charles I. Thomas and Dr. William E. Bruner received the distinguished service award of the Cleveland Community Fund for outstanding work in the field of sight restoration.

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9 MINUTES AFTER TREATMENT

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Arch. Otolaryng., 39:109-123, 1944.

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In Memoriam

Ray Anderson Bohl, M.D., Stow; Ohio State University College of Medicine, 1931; aged 44; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Sept. 19. A veteran of World War I, Dr. Bohl practiced in Stow for 12 years. He was a member of the Masonic Order, American Legion and the Church of Christ. Surviving are his widow, two daughters, a son and a sister.

Harry Maxwell Box, M.D., Coral Gables, Fla.; Miami Medical College, Cincinnati, 1907; aged 61; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; died Sept. 30. Dr. Box retired in 1938, after having practiced in Cincinnati for over 30 years. He was a former member of the staff at Deaconess Hospital. His widow survives.

Walter William Brand, M.D., Toledo; Jefferson Medical College, Philadelphia, 1894; aged 73; former member of the Ohio State Medical Association and former Fellow of the American Medical Association and the American College of Surgeons; died Oct. 2. One of the pioneers in medicine, public health and hospital building in Toledo, Dr. Brand was chief of staff of Women's and Children's Hospital for 25 years, an institution which was built largely through his efforts. A former city health commissioner, it was during his administration that the city's contagious disease hospital was built, and he was also a member of the commission which supervised the building of the Lucas County Hospital. Dr. Brand was honorary president of the Ohio Obstetrical Society. He was a member of the Congregational Church, Elks Lodge and a former president of the Torch Club, a discussion group made up of civic leaders. His widow and a daughter survive.

Oscar Eisinger, M.D., Cleveland; University of Vienna, Austria, 1915; aged 54; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Oct. 4. Dr. Eisinger came to the United States in 1924. During the first World War he was a captain in the Medical Corps of the Austrian Army. Since the Selective Service System went into effect, he had served as a medical examiner at the Cleveland Induction Station. Well known in musical circles, he had been a member of the Cleveland Singers' Club for 20 years. Surviving are his widow, a sister in England and one who arrived in Cleveland recently after escaping from occupied Europe. Three brothers in Europe have not been heard of for years.

Eliezer Israel Fogel, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1909; aged 58; former member of the Ohio State Medical Association and the American Medical Association; died Sept. 11. Dr. Fogel retired from active practice two years ago because of ill health. He had been in Cincinnati for 35 years and was a member of the staff of Jewish Hospital. During World War I, Dr. Fogel was a physician in the Army. He was active in civic work and in the Zionist movement and a member of the Masonic Order. Surviving are his widow, a daughter, two sons and four brothers.

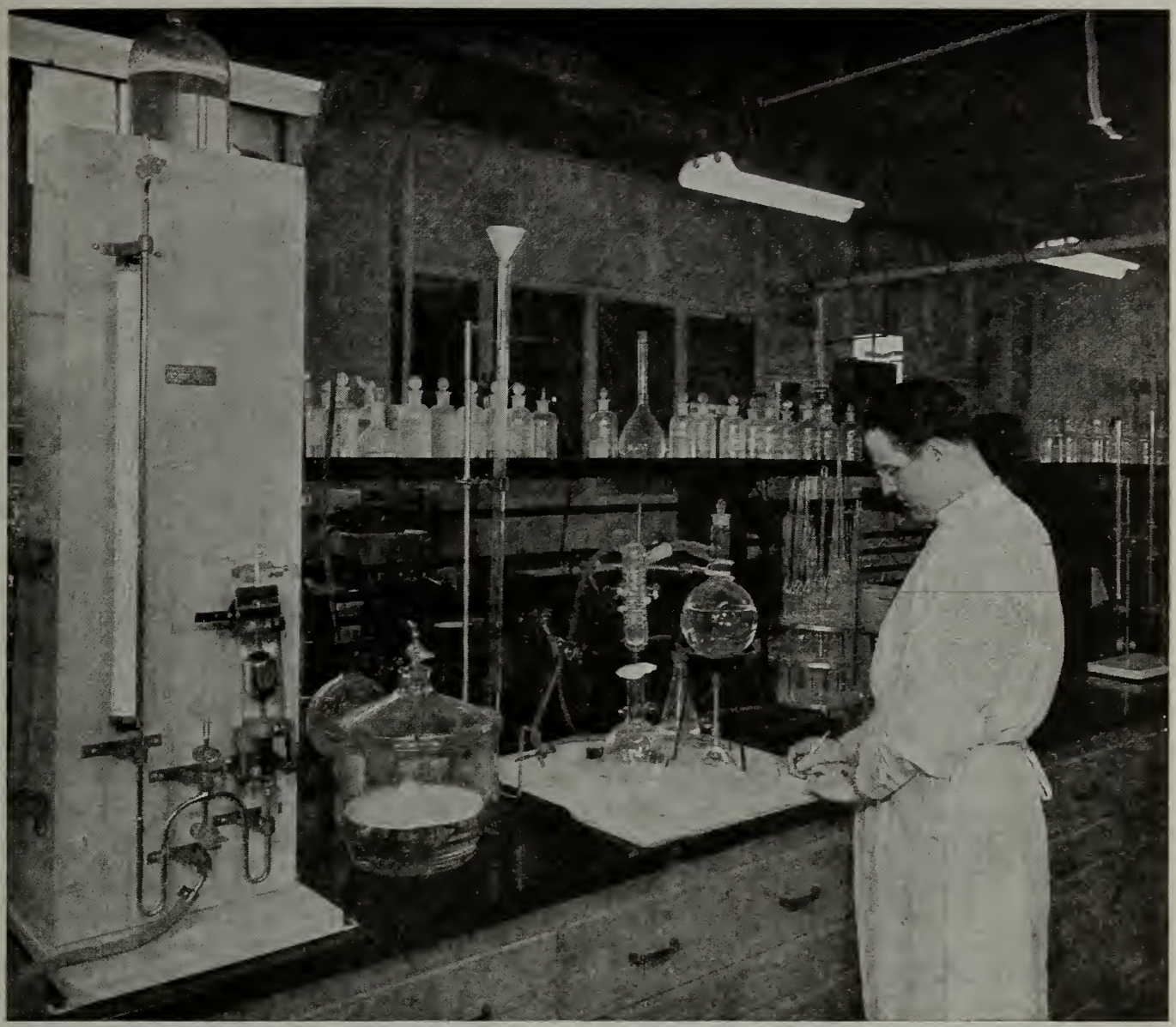
William Henry Hogue, M.D., Marietta; University of Louisville School of Medicine, Louisville, Ky., 1894; aged 75; died Sept. 21. Dr. Hogue practiced in Beverly, Washington County, until 1920, when he moved to Marietta. He had been in ill health for eight years. Dr. Hogue was a member of the Episcopalian Church. His widow, a daughter and four sisters survive.

Jesse Whipps Hull, M.D., Toledo; Cincinnati College of Medicine and Surgery, 1897; aged 81; died Sept. 19. Dr. Hull retired in 1940, after having practiced in Toledo for 40 years. He was a member of the Masonic Order.

Carl Aaron Hyer, M.D., Columbus; Ohio State University College of Medicine, 1920; aged 53; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Oct. 13. Dr. Hyer, a member of the staff of Mt. Carmel Hospital, practiced in Columbus for nearly 20 years, after three years at the Mayo Clinic. Prominent in athletics, especially football, while a student at Ohio Wesleyan University, he coached football at Capital University, Columbus, while in medical school, and later worked as a football official for many years in the Ohio Conference. His son and a sister survive.

William George Martin, M.D., Columbus; University of Toronto Faculty of Medicine, Ontario, 1911; aged 56; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Sept. 6. Dr. Martin, a medical examiner for the Norfolk & Western Railroad for 26 years, had been a resident of Columbus for seven years. He had previously lived in Kenova, W. Va.

Francis A. Leslie, M.D., Toledo; Bellevue Hospital Medical College, New York, 1894; aged 80; member of the Ohio State Medical Association and the American Medical Association; died Sept. 6. After nearly 45 years of prac-



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DIED WHILE IN MILITARY SERVICE

Frank John Fischer, M.D., Chagrin Falls; University of Wisconsin Medical School, Madison, 1934; aged 35; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; Captain, Medical Corps, Army of the United States; died Sept. 21, as a result of a plane crash following a forced landing 20 miles west of Leesburg, Va., while en route to a surgical conference at Dayton. He was chief of the surgical service, Station Hospital, Camp Springs Air Field, Washington, D.C. Capt. Fischer entered the Air Corps, United States Army, in September, 1942. Prior to that time he had been very active in medical circles in Cleveland and vicinity. After finishing his surgical training at St. John's and Cleveland City Hospitals in 1938, he entered private practice at Chagrin Falls. Before beginning Army service, Capt. Fischer had become interested in flying. He was certified as a commercial pilot by the Civil Aeronautics Commission on July 1, 1942. While serving in the Army Medical Corps, he attended the School of Aviation Medicine and became certified as an aviation medical examiner. Surviving are his widow, a son and three daughters.

* * *

George Forster Hilles, M.D., Cleveland; Western Reserve University School of Medicine, 1939; aged 31; Captain, Medical Corps, Army of the United States; killed in a plane crash over Italy on August 23. Capt. Hilles was attached to the Mediterranean Air Transport Service. After entering service in May, 1941, he spent 19 months in Panama. Following a short time in the United States, he was re-assigned to the Italian Theater. Capt. Hilles was a former resident physician at Deaconess Evangelical Hospital, Cleveland. His parents survive.

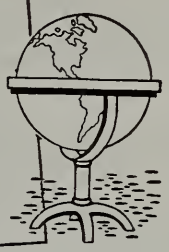
* * *

Rowland Daniel Wolfe, M. D., Columbus; George Washington University School of Medicine, Washington D. C., 1908; aged 59; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; Lieut. Col., Medical Corps, United States Army; died Sept. 29, at Fletcher General Hospital, Cambridge. Col Wolfe entered the Army Medical Corps in 1916, and was with the AEF in France during World War I. Later he served in Hawaii and stations in the United States, before retiring from active duty Feb. 28, 1939. Recalled to active duty on Sept. 11, 1940, Col Wolfe was assigned as senior instructor in the ROTC Medical Unit at Ohio State University, and was appointed assistant professor of military science there. When the Army Special Training Program was established in June, 1943, he was appointed commanding officer of the medical battalion. His widow, a son and a daughter survive.

tice, Dr. Leslie retired five years ago. He had served on the staffs of Toledo, St. Vincent's and Robinwood Hospitals, and even after retirement from active practice, continued to serve on the advisory council of the Toledo District Nurses' Association. Dr. Leslie was a member of the Congregational Church. Surviving are his widow, a son, two sisters and a brother.

Sidney Morrill McCurdy, M.D., East St. Johnsbury, Vt.; Western Reserve University School of Medicine, 1904; aged 63; former member of the American Medical Association and Fellow of the American Medical Association; died Sept. 26. A native of Andover, Mass., where his father was a professor of Andover Academy, Dr. McCurdy began the practice of medicine in Youngstown in 1904. From 1914 to 1932 he was chief surgeon for the Youngstown Sheet and Tube Company. During World War I Dr. McCurdy served as a captain in the Medical Corps of the U.S. Army, with 16 months' service in France as adjutant and detachment commander of Base Hospital Unit No. 31 and battalion surgeon, Second Battalion, 18th Infantry, First Division. On March 1, 1936, Dr. McCurdy was appointed supervisor of the Medical Section of the State Industrial Commission, a post from which he resigned on January 1, 1941. Shortly after the outbreak of World War II, he came back to Ohio temporarily from Vermont to organize the medical staff at the Plumbrook Ordnance Plant near Sandusky. After his return to Vermont, he gave considerable time to civilian defense activities and was medical officer of O.C.D., Eastern Vermont. For 30 years a member of the staff of the Youngstown Hospital, Dr. McCurdy was a former president and secretary of the Mahoning County Medical Society and the organizer and first president of the Youngstown Medical-Dental Bureau. Ever active in behalf of the profession, he had represented the society in the House of Delegates of the Ohio State Medical Association. Dr. Mccurdy was a charter member of the American

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241. N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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Association of Industrial Physicians, and a former director of that association. While in Youngstown, he was active in the Chamber of Commerce, Allied Council and the Unitarian Church. His widow, a daughter and two brothers survive.

William Edward Merrick, M.D., Cleveland; University of Wooster, Medical Dept., Cleveland, 1908; aged 60; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Oct. 11. A practicing physician in Cleveland for 36 years, Dr. Merrick was a member of the staffs of St. Vincent Charity, St. Ann's Maternity and St. John's hospitals. He was a member of the Catholic Church. Surviving are his widow and two sisters.

William Otto Pauli, M.D., Cincinnati; Johns Hopkins University School of Medicine, Baltimore, Md., 1907; aged 62; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Sept. 16. Dr. Pauli became associated with the Union Central Life Insurance Company shortly after his graduation from medical school, and was assistant medical director of the company at the time of his death. His widow, two daughters, a brother and a sister survive.

Joseph William Robinson, M.D., Lisbon; Eclectic Medical College, Cincinnati, 1927; aged 50; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Sept. 21. Dr. Robinson practiced in Lisbon for 15 years. He was a former president and vice-president of the Columbiana County Medical Society. Dr. Robinson was a member of the Presbyterian Church, the Masonic Order, and the American Legion, having served in the Navy during World War I. Surviving are his widow, a son, a daughter and a sister.

Chester A. Spitler, M.D., Middletown; Indiana Medical College, School of Medicine of Purdue University, Indianapolis, 1907; aged 66; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Sept. 14. A former city health commissioner, Dr. Spitler practiced in Middletown for 28 years. He was a member of the staff of Middletown Hospital for a number of years. Dr. Spitler was a member of the Masonic Order. His widow, a son, two sisters and two brothers survive.

Sterling B. Taylor, M.D., Columbus; Starling Medical College, Columbus, 1890; aged 75; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; died Sept. 21. Dr. Taylor retired, after nearly 50 years in practice, on Jan. 4, 1939. For many years he was chief surgeon for the New York Central Railroad in Columbus, and was a former president of the American Association of Railway Surgeons and the Chief Railway Surgeons Association. Dr. Taylor was on the faculty of Ohio Medical College and Starling Medical College. He had been a major in the Medical Department of the Ohio National Guard. Dr. Taylor was a member of the Masonic Order and the Elks. His widow and two sons survive.

David Thomas, M. D., Lorain; University of Michigan Medical School, Ann Arbor, 1912; aged 59; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Oct. 19. An active practitioner in Lorain for over 30 years, Dr. Thomas was a member of the Board of Censors of the Lorain County Medical Society and a former president and vice-president of the society. He was a trustee of Pleasant View Sanatorium and a former president of the staff of St. Joseph's Hospital. During World War I Dr. Thomas was a lieutenant in the Medical Corps of the United States Army. He was a member of the Congregational Church, Masonic Order, Elk's Lodge and a past-president of the local Rotary Club. Surviving are his widow, two daughters and a brother.

John Kirkland Tressel, M.D., Alliance; University of Wooster, Medical Dept., Cleveland, 1902; aged 66; former member of the Ohio State Medical Association and the American Medical Association; died Oct. 16, in the Veterans' Administration Hospital, Dayton, after 11 years' illness. Dr. Tressel formerly practiced in Alliance. He was a veteran of the Spanish-American War and World War I. His widow and a sister survive.

Charles R. Wallace, M.D., Struthers; Cleveland Medical College, Homeopathic, 1897; aged 78; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Sept. 30. Originally a school teacher in Lawrence County, Pa., Dr. Wallace practiced medicine in Cleveland for two years following graduation and then settled in Struthers. He had been a member of the village council, board of education and board of health. Dr. Wallace was a member of the Methodist Church and the Masonic Order. Surviving are his widow and a sister.

Alice Antoinette Pendleton, M.D., Cleveland; University of Oklahoma School of Medicine, Oklahoma City, 1927; aged 42; member of the Illinois State Medical Society and Fellow of the American Medical Association, died October 16. Dr. Pendleton practiced in Decatur, Ill., until two years ago. She was planning to begin practice in Cleveland when ill health

forced her retirement. Her mother and two brothers survive.

Arthur Garfield Ringer, M.D., Cambridge; Ohio Medical University, Columbus, 1904; aged 64; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Sept. 30. Dr. Ringer practiced in Cambridge for nearly 40 years. He was coroner of Guernsey County from 1908 to 1912. Dr. Ringer was a member of the Methodist Church, the Masonic Order and the Alpha Kappa Kappa fraternity. Surviving are his widow, a son, Capt. Robert Ringer, M.C., A.U.S., and two sisters.

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If your *Journal* is late in reaching you these days, be patient. The mails are clogged and there is a shortage of labor at our print shop. Wait until the 15th of the month before assuming your *Journal* has gone astray. If you don't get it by then, drop us a line and we will mail you a copy if extra copies are available.

Correction in Program

A correction has been made in the series of programs to be presented by the Cincinnati Academy of Medicine during the ensuing year and referred to on page 980 of the October issue of *The Journal.* The meeting which will be sponsored by the Cincinnati Nutrition Council will be held on March 20, 1945, instead of March 10 as published.

Coming Meetings

Ohio State Medical Association, Columbus, May 1-3, 1945.

American Academy of Pediatrics, St. Louis, Nov. 9-11.

Association of Military Surgeons of the United States, New York City, Nov. 2-4.

Annual Conference of State Secretaries and Editors, Chicago, Nov. 17-18.

Southern Medical Association St. Louis, Nov. 13-16.

Western Surgical Association, Chicago, Dec. 1-2.

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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

Members of the Adams County Medical Society were guests of their West Union colleagues at a meeting there on Oct. 18. The program for the morning session consisted of a business meeting, a discussion of "Medical Legislation", by Dr. S. C. Clark, Cherry Fork, and an address entitled "The Adams County Medical Society of 1860", by Dr. Hazel L. Sproull, West Union. Following the dinner, Dr. Robert Woolford, Cincinnati, spoke on "The Anemias".—Hazel L. Sproull, M. D., secretary.

BUTLER

Dr. Stanley T. Garber, assistant professor of obstetrics, University of Cincinnati College of Medicine, spoke on "The Toxemias of Pregnancy", at a meeting of the Butler County Medical Society, Sept. 28, at the Fort Hamilton Hospital, Hamilton.—Azel Ames, M. D., president.

CLINTON

At a well-attended meeting of the Clinton County Medical Society, Oct. 3, at the General Denver Hotel, Wilmington, Dr. R. W. DeCrow, county health commissioner, spoke on "Immunity".—R. W. DeCrow, M. D., secretary.

HAMILTON

The following programs were presented by the Cincinnati Academy of Medicine during October:

Oct. 3—"Penicillin", Dr. Chester S. Keefer, professor of medicine, Boston University School of Medicine, Boston, Mass.

Oct. 17—"Psychotherapy in Medical Practice", Dr. Lawrence Kubie, associate psychiatrist, Mt. Sinai Hospital, New York City—Bulletin.

HIGHLAND

Members of the Highland County Medical Society were the guests of the county board of health at a luncheon meeting, Sept. 20, at the Hotel Parker, Hillsboro. The topic for discussion was "What Can We Do to Improve Our Health Department?".

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

MIAMI

"The Future of Physical Medicine", was the subject of an illustrated talk given by Dr. H. Worley Kendell, Surgeon (R), U.S.P.H.S., director of the Chicago Intensive Treatment Center, at a meeting of the Miami County Medical Society, Oct. 6, at Stouder Hospital, Troy. Dr. Kendell son of Dr. H. W. Kendell, Covington, president of the society, was formerly director of the Department of Physical Medicine at Miami Valley Hospital, Dayton.—G. A. Woodhouse, M. D., secretary.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M. D., TOLEDO)

LUCAS

The Toledo Academy of Medicine presented the following programs during October:

Oct. 6—General Meeting. "Poliomyelitis", Dr. Franklin H. Top, medical director, Herman Kiefer Hospital and the Detroit Department of Health.

Oct. 20—Medical Section. "The Treatment of Diabetic Acidosis and Coma", Dr. Jerome W. Conn, assistant professor of internal medicine, University of Michigan Medical School.

Oct. 27—Surgical Section. "Scalenus Anticus Syndrome", Dr. Edwin R. Murbach, Archbold.—Bulletin.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

CUYAHOGA

The following programs were presented by the Cleveland Academy of Medicine during October:

Oct. 6—Clinical and Pathological Section. "Tantalum Cranioplasty", Dr. W. F. Gardner; "Hemangioma of the Arm", Dr. U. V. Portmann; "Islet Cell Tumor of Pancreas", Dr. Robert Schneider; "Pyrexia of Undetermined Origin", Dr. John Tucker; "Wilms Tumor of the Kidney", Dr. Charles C. Higgins.

Oct. 13—Joint Meeting, Experimental Medical Section and Cleveland Section of the Society for Experimental Biology and Medicine. "Clinical and Experimental Studies of Toxoplasmosis", Dr. Lorand V. Johnson and Carol Connors, A. B., with discussion by Dr. Robert F. Parker and Dr. Carroll C. Dundon; "Studies on Steroid Excretion in a Case of Adrenal Cortical Carcinoma", Dr. Hans Hirschman and Frieda B. Hirschmann, Ph.D.; "Metabolism of the Kidney in Experimental Hypertension", Sigwin B. Raska, Ph.D.—Bulletin.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

MAHONING

Dr. Frederick R. Mautz, assistant professor of surgery, Western Reserve University School of Medicine, Cleveland, spoke on "Clinical Aspects of Biochemical Disturbances in Surgical Patients", at a meeting of the Mahoning County Medical Society, September 19, at the Youngstown Club, Youngstown. Drs. A. E. Brant,



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W. D. Collier and F. W. McNamara participated in a discussion of "Cancer", at a meeting of the society, October 17, at the Youngstown Club.—Bulletin.

PORTAGE

Dr. George B. Dochat, director of laboratories, People's Hospital, Akron, spoke on "Some Considerations in the Pathologic Diagnosis and Prognosis of Carcinoma of the Stomach", at a meeting of the Portage County Medical Society, October 5, at Robinson Memorial Hospital, Ravenna.—Emily Widdecombe, M. D., secretary.

SUMMIT

Dr. F. M. Barry, Cleveland, spoke on "Clinical Uses of Penicillin", at a meeting of the Summit County Medical Society, October 3, at City Hospital, Akron. Members of the Woman's Auxiliary were guests and served refreshments at the close of the meeting.—Bulletin.

Seventh District

(COUNCILOR: CARL A. LINCKE, M. D., CARROLLTON)

TUSCARAWAS

"Practical Endocrine Therapy in the Female", was the subject of an address made by Dr. George H. Irvin, Cleveland, at a meeting of the Tuscarawas County Medical Society, October 12, in the Council Chamber, New Philadelphia. There were 25 members present.—D. M. Ceramella, M. D., secretary.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

GUERNSEY

Major Peter C. Rizzo, M. C., chief of the orthopedic surgical section, Fletcher General Hospital, Cambridge, discussed the reconditioning of soldiers at that institution, at a meeting of the Guernsey County Medical Society, October 5, at Cambridge.—M. S. Lawrence, M. D., secretary.

MUSKINGUM

A special meeting of the Muskingum County Academy of Medicine was held on September 27, at the University Club, Zanesville, for the purpose of hearing a talk on "Absorption of Lead in Industry", by Dr. Elston L. Belknap, consultant for the Employer's Mutual Insurance Company, and the National Battery Company.—Beatrice T. Hagen, M. D., secretary.

Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

FRANKLIN

The Columbus Academy of Medicine presented the following programs during October:

Oct. 2—"The Surgical Approach to Coronary Heart Disease", Col. Claude S. Beck, M.C., Surgical Consultant, Fifth Service Command, with discussion by Lt. Col. Johnson McGuire, Medical Consultant, Fifth Service Command, and Dr. R. W. Kissane, lecturer in cardiology, Ohio State University College of Medicine.

Oct. 16—"Fractures About the Hip", Dr. Paul H. Harmon, Sayre, Pa. X-ray demonstrations preceded each meeting.—Bulletin.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M. D., SANDUSKY)

LORAIN

Dr. J. L. Reycraft, Cleveland, spoke on "The Study of Sterility", at a meeting of the Lorain



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County Medical Society, October 10, at the Lorain Country Club, Lorain.—L. H. Trufant, M. D., secretary.

WOMAN'S AUXILIARY NEWS

(BY MRS. FRED W. BROSIUS, MIDDLETOWN)
Chairman, Publicity Committee

BUTLER

The Board of Directors of the Woman's Auxiliary of the Butler County Medical Society, in a meeting at the Hamilton Y.W.C.A., September 11, formulated plans for the coming year. Programs were outlined for October, December, February, April and June.

A joint meeting with the Butler County Medical Society and the Union District Medical Association was held at the Anthony Wayne Hotel, Hamilton, on October 25, when Mrs. Cleo Dawson Smith, prominent dramatic artist, provided the entertainment. About 100 guests attended from southern Ohio and adjacent Indiana counties. Dr. Azel Ames, President of the Butler County Medical Society, and Mrs. Ames, Chairman of Hostesses, had charge of the arrangements.

The Butler County Auxiliary Board of Directors is composed of: Mrs. Harry Burdsall, President; Mrs. Ross Hill, Vice-President; Mrs. W. H. Williams, Past-President; Mrs. Fred Brosius, President-Elect; Mrs. Clyde Stafford, Recording Secretary, Mrs. Vernon Roden, Corresponding Secretary; Mrs. J. Alfred Mackie, Treasurer; Mrs. H. J. Baker, Mrs. Walter Roehll and Mrs. Arnold Leeds.

A project of Middletown members will be to act as hostesses at the monthly medical lectures given by the Doctors' Staff of Middletown Hospital, for the Red Cross Nurse's Aide Corps.

KNOX

Mrs. John Drake, President of the Woman's Auxiliary to the Knox County Medical Society, was hostess to the members on Wednesday evening, October 4, at her home on Edgewood Road, Mt. Vernon. The following committees were appointed: Program, Mrs. J. F. Lee, Mrs. Julius Shamansky, and Mrs. O. W. Rapp; Publicity and Public Relations, Mrs. Shamansky; Hygeia, Mrs. W. W. Pennell, Mrs. Charles Baldwin, and Mrs. E. V. Ackerman; Legislative, Mrs. H. W. Miller; Historian, Mrs. Rapp; Membership, Mrs. George Imhoff; Flowers, Mrs. J. M. Pumphrey. Meetings will be held the first Wednesday evening of every month except January. Mrs. Lee, Mrs. John Claypool, Mrs. Drake and Mrs. Imhoff were in charge of refreshments served at Mercy Hospital's twenty-fifth Jubilee Celebration recently.

LUCAS

Officers of the Woman's Auxiliary of the Academy of Medicine of Toledo and Lucas County for the ensuing year are as follows: Mrs. W. F. Maxwell, President; Mrs. F. B. McNierney, President-Elect; Mrs. J. L. Stifel, Vice-President; Mrs. J. E. Minns, Corresponding Secretary; Mrs. H. D. Brown, Recording Secretary; Mrs. F. B. Ficklin, Treasurer and Mrs. N. W. Kaiser, Assistant Treasurer. Mrs. W. W. Beck is the retiring President. Membership is over 200.

MARION

The Woman's Auxiliary to the Marion Academy of Medicine launched their Fall and Winter activities, by presenting a style show and bridge party, Wednesday, September 27, at the Marion Country Club. The capable committee who was responsible for the success of this project was: Mrs. Fillmore Young, general chairman; Mrs. J. W. Jolly, Mrs. M. M. Weinbaum, Mrs. E. H. Morgan, Mrs. Frederick Merchant, Mrs. Richard Morgan, Mrs. Harry Merchant, and Mrs. H. K. Mouser. Tables for bridge were arranged and refreshments were served at the sandwich bar. Mrs. J. A. Dodd is President of the Auxiliary, and Mrs. Carl W. Sawyer, Vice-President.

ROSS

The Woman's Auxiliary to the Ross County Academy of Medicine, Chillicothe, Ohio, held the first regular meeting, Thursday evening, Sep-

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tember 7. After an enjoyable dinner at Allyn's Dining Room, a business session and program were held at the Y.M.C.A. The President, Mrs. W. C. Breth, presided and led a discussion on projects for the coming year. Each member was asked to present a project suggestion at the next meeting, Oct. 5. A motion was made and adopted to sew every Tuesday at the Red Cross Production Rooms. Mrs. L. T. Franklin, program chairman, introduced Miss Alice Myers, guest speaker. A travel talk on a recent visit to Guatemala, with pictures and costumes of the regions discussed was given in a very interesting manner.

The second regular meeting of the Auxiliary was held Thursday evening, October 5, at Chillicothe. Mrs. Walter Breth presided. Thirteen of the 24 members were present. Miss Olive Newman, a missionary in India for six years, was guest speaker. The members voted to place *Hygeia* in all Ross County High School libraries for a year. Mrs. John Franklin, chairman of the Bond Drive for the hospital plane, which was sponsored by the women of Ross County, gave a splendid report of the Bonds purchased by the Auxiliary. Next meeting will be held Thursday, November 2.

News Notes

Akron—Dr. Roger E. Pinkerton spoke on "Socialized Medicine" at a meeting of the Barberton Kiwanis Club.

Bucyrus—How the passage of the Wagner-Murray-Dingell Bill would affect the public was explained by Dr. W. G. Carlisle at a meeting of the Rotary Club.

Chillicothe—Dr. B. L. Chipley, superintendent of Mt. Logan Sanitarium, spoke on "Diseases of the Chest", at a meeting of the Altrusa Club.

Cleveland—Dr. E. P. Edwards, for many years in the Tuberculosis Bureau of the City Division of Health, has been named health commissioner of Cleveland Heights, succeeding Dr. Robert Lockhart, retired.

Jackson—Fifty years as a general practitioner is the record of Dr. J. S. Hunter, eight years in Piketon and 42 years in Jackson.

Norwalk—Dr. George F. Linn is a new member of the local Board of Education.

Wilmington—"Medicine, Yesterday, Today, Tomorrow", was the subject of an address made by Dr. Robert Conard at a meeting of the Lions Club.

Youngstown—An address on "Cancer Control" was made by Dr. W. D. Collier at a meeting of the Quota Club.

Zanesville—Dr. Charles Roach was re-elected president of the staff of Good Samaritan Hospital. Other officers re-elected were: Dr. Herman B. Kauffman, vice-president and Dr. Robert S. Martin, secretary.

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JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.* GEORGE H. SAVILLE, *News Editor*

The Dysenteries

EDWARD L. TURNER, M.D.

THE dysenteries seen in man may be classified roughly as follows:

1. Bacillary Dysenteries — (a) Shigella dysenteriae (Shiga-Kruse type); (b) Shigella paradysenteries (Flexner, Hiss, Strong, etc.).

2. Protozoal Dysenteries—(a) Amebiasis (Endamoeba histolytica; (b) Other intestinal protozoal dysenteries; (1) Balantidial dysentery, (2) Malarial dysentery, (3) Leishmanial dysentery (Kala-Azar), (4) Intestinal coccidiosis.

3. Helminthous Dysenteries—(a) Schistosomal dysenteries; (b) Others (such as Oesophagostomum apiostomum).

4. Flagellate Dysenteries—(a) Giardia; (b) Trichomonas, etc.

A. Bacillary Dysenteries.

From ancient times, Bacillary Dysentery has been one of the great problems facing military and civilian physicians. Hippocrates[1] describes classical dysentery cases in Section No. 8 "Of The Epidemics". It was a great scourge in the old Persian armies, caused many casualties during the Crimean War, and decimated Napoleon's Army as it retreated from Moscow. During World War One, it created havoc among the British troops in the Gallipoli Campaign where, Manson-Bahr[2] states, it was responsible for the majority of the 120,000 medical casualties evacuated from the peninsula within three months' time. Callender[3] points out that Bacillary Dysentery in the United States Army has shown an increase during periods of military activity.

Weil[4] reports that Bacillary Dysentery has increased somewhat in the United States during the past ten years. In 21 states reporting dysentery cases, there has been an increase in Bacillary Dysentery with a decrease in the number of unclassified dysenteries.

Bacillary Dysentery occurs most frequently in the warm months and outbreaks are closely related to the state of sanitation. Topley[5] and Dudgeon[6] have shown that flies play a role in spreading the disease and Griffitt's[7] has demontrated that ants can carry dysentery bacilli on their feet from infected matter to unprotected food. Weil[8] states that the vehicle by which dysenteric infection is carried from one locality to another is rather exclusively man.

Human carriers are of importance in evaluating the spread of Bacillary Dysentery. Many dysentery patients become carriers. A study of 6,000 healthy individuals in New York City detected 2 per cent carriers. Other studies in New Mexico, Georgia, and Puerto Rico revealed an incidence of 3.2 per cent carriers in individuals with no history of diarrhea or recent intestinal complaints. Dysentery convalescents may harbor bacilli for several months. Since they are otherwise healthy, they may be serious sources in spreading the disease. Bojlen[9] and Kobayashi[10]

Presented at the Fourth General Session, Ninety-Eighth Annual Meeting, Ohio State Medical Association, Columbus, May 2-4, 1944.

The Author

● Dr. Turner, Nashville, Tenn, is a graduate of University of Pennsylvania School of Medicine, 1928; diplomate, American Board of Internal Medicine; fellow, American College of Physicians; member, Central Soc. for Clinical Research, Soc. for Experimental Biology and Medicine, and Assn. of American Physicians; chief, Medical Service, Geo. W. Hubbard Hosp.; professor of medicine, and president of Meharry Medical College.

feel that convalescent temporary carriers are the most important sources of spread of infection.

For all practical purposes, Strong [11] states that for diagnosis and treatment, it is sufficiently satisfactory to separate the important dysentery bacilli into two main types as has been indicated in the classification at the beginning of this paper. In general, Shigella dysenteriae occurs more commonly in the tropics than in the temperate regions and is responsible for the more severe clinical forms and the most virulent epidemics. Besides, the true dysentery bacilli there are a number of "dysentery-like" bacilli such as Morgan's Bacillus which are associated with diarrheic conditions and which add to the general confusion in regard to the complete picture of the bacteriology of Bacillary Dysentery.

The clinical picture produced by Bacillary Dysentery is an exceedingly variable one. It is easy to diagnose in its severe forms. In the more severe cases, the patient has a short incubation period of from a few hours to six or seven days, usually becomes acutely and seriously ill. The griping pains, tenesmus, frequent, loose, scanty and bloody stools are fairly typical. These patients have in truth what Manson-Bahr calls "lying down dysentery". The speed with which these patients can become toxic, dehydrated and desperately ill is astonishing, and early diagnosis and adequate treatment are essential if lives are to be saved. However, it must be emphasized that this is only one picture of the many that can result from infections with dysentery bacilli. Acute cases occurring in epidemics may have from 20-60 or more stools daily, but many of the mild cases of dysentery may experience simply a little general malaise, a slight fever and a few loose stools. In fact, epidemics have been reported where nausea and vomiting have been the chief clinical manifestations.

Many authorities in this field are convinced that vague diagnostic terms such as "summer diarrhea," "intestinal flu," "climatization diarrhea," and others should be completely discarded from the vocabulary of physicians. When such conditions are thoroughly studied, they are usually found to be infections with Sonne bacilli and organisms of the Flexner group. Careful laboratory studies will quickly reveal the fallacy of diagnosing intestinal flu, and the use of other "refuge" terms.

The stools of a typical Bacillary Dysentery patient contain very little feculent material. The fresh specimen shows, in addition to the dysentery bacilli, pus cells and large endothelial macrophages. These macrophages are almost diagnostic of Bacillary Dysentery when they are present and must be differentiated from amoeba since they contain red blood corpuscles also. In warm preparations, amoeba, if present, will show motility, while the macrophages of the Bacillary Dysentery stool are non-motile. The dysentery bacilli can be grown easily in the laboratory, and then tested with anti-sera and other means to determine their species.

PROTECTION

Protection against infection from dysentery bacilli is largely a matter of personal hygiene and adequate care in handling of dysentery patients by physicians, nurses, and other attendants. The same general sanitary measures employed in preventing other enteric infections are necessary in the prevention of the spread of Bacillary Dysentery. Although evidence gradually accumulates that prophylactic vaccination may ultimately be of some value, the available studies do not warrant the recommendation of the use of dysentery vaccines as a general prophylactic measure. The S G O Circular Letter[12] from the Office of the Surgeon General of the United States Army dated February 2, 1943, also states that the value of vaccination has never been satisfactorily demonstrated for this disease.

Until the advent of the sulfonamides the treatment of Bacillary Dysentery was not very satisfactory. If one was fortunate enough to be located where laboratory facilities could quickly determine the type of organisms, and where specific anti-dysenteric sera were available, sometimes much benefit resulted from the use of monovalent Shiga dysentery serum. Many polyvalent sera have been prepared for Bacillary Dysentery, but their value has been questionable. It is certainly true that if serum is to be used, it must be given in adequate quantities, and the earlier it is given the better the potential results. In acute dysentery cases from 60 to 80 cc of serum can be given intravenously twice daily after testing the patient for sensitivity. It is best to give the serum well diluted in normal saline and always administer it slowly. Such quantities of serum can be repeated for three to four days, or until the temperature falls to normal level.

It was formerly common practice to purge patients with Bacillary Dysentery. Clinicians frequently gave magnesium sulfate, sodium sulfate, or castor oil at the beginning of the treatment on the theory that they were washing out bacteria and toxic materials. One wonders how many patients already seriously dehydrated from their dysentery had their "fluid balance" still further and more dangerously disarranged by such procedures. Fortunately, during the past several years, advocation of this method of purging as a routine part of therapy in Bacillary Dysentery has been gradually disappearing from our textbooks.

SULFAGUANIDINE

At the present time, sulfaguanidine is the drug of choice in the treatment of Bacillary Dysentery. For an average adult the initial

dose should be 3.5 grams. Because of its relatively low solubility, the follow-up doses can be maintained at the level of 3.5 grams every four hours around the clock. This is continued until the number of stools is reduced to four or five during a 24-hour period. Subsequent doses of 3.5 grams of sulfaguanidine are then given, the clock around, every eight hours until the stools have been normal for four days. If the patient does not respond satisfactorily, the drug should be discontinued after a week, other methods then being resorted to.

If sulfaguanidine is not available, it is possible to use sulfathiazole or sulfadiazine. For an average adult the initial dose is four grams either in a single dose or in divided doses of two grams given two hours apart. Because these drugs are more toxic than the sulfaguanidine, the follow-up dose is one gram every four hours around the clock. Roberts and Daniels[13] recently reported their results in the treatment of 225 soldiers ill with Shigella paradysenteriae Boyd-88 type dysentery with succinyl sulfathiazole. They observed that the succinyl sulfathiazole did not shorten the relatively short lasting disease, but that it did reduce the incidence of carriers from 18.2 to 2.6 per cent.

Chronic Bacillary Dysentery is treated with administration of 3.5 grams of sulfaguanidine every eight hours around the clock until adequate results have been obtained. Such treatment should not be kept up longer than two weeks.

It is still important to call attention to the fact that the intensive use of sulfonamides in therapy should be accompanied by adequate fluid intake, thereby keeping up a daily urinary output of 1,500 cubic centimeters or more to avoid crystal deposition in the urinary tract. Because of the dehydration and the toxemia observed in the average bacillary dysentery case, it is advisable that a fluid intake of at least 3,000 cubic centimeters per day be kept up. In the severe cases the fluid intake may have to be maintained by the use of intravenous saline and glucose.

The remainder of the treatment of Bacillary Dysentery is symptomatic and supportive. These patients should be at absolute rest in bed. Their abdominal discomfort frequently is greatly alleviated by the use of heat in the form of a hot-water bottle or an electric pad. The tenesmus is so troublesome at times that morphine is required to give rest. The diet is important and sometimes difficult to arrange. These patients develop an anorexia frequently from the fear of eating because it initiates increased intestinal peristalsis. Frequent small feedings of liquid material are best in acute stages.

For some reason Bacillary Dysentery patients do not do well on milk unless it has been treated with citric acid or prepared in the form of protein milk. Bouillon, lactose and tea, small eggnogs, with a dash of brandy, and foods of this type are helpful. Every effort should be made to administer a high caloric diet containing an adequate amount of protein, moderate amount of fat, and easily assimilable carbohydrate. Any residue-forming food should be avoided early in the illness. As the patient improves custards, soups, cereals, and other easily digested foods can be added. Feedings should continue to be small and frequent until the patient is well along in convalescence.

COMPLICATIONS

The complications of Bacillary Dysentery, such as arthritis, eye disorders, parotitis, and the sequelae, such as stenosis, neuritis, persistent colitis, and the development of the Bacillary Dysentery carrier, are all problems that must be handled as these various situations arise. As indicated earlier in this resume, probably three per cent or more of recovered cases of Bacillary Dysentery develop a carrier state that may last for several months to a year or longer. Proper hygienic education is definitely required in the case of these carriers, as well as therapeutic efforts to rid them of their bacteria.

B. Protozoal Dysenteries. (1) Amebiasis.

Although the most important pathological conditions produced in man infected with Endamoeba histolytica result from primary infections of the intestines, the actual clinical manifestations observed may be numerous and, at times, bizarre. There are several species of amoeba that may be observed in the intestinal canal of human beings but Endamoeba histolytica is the only one that seems to produce pathological changes.

Amebiasis is widespread. It is seen almost everywhere, in the tropics and sub-tropics, but it is by no means limited to these areas. It is most common in the warm regions of the Americas, Asia, Africa and the East and West Indies. It is also found in many different parts of Europe. Here in the United States, it is relatively more common in the South, than in other regions of the country. It is not diagnosed more commonly for the simple reason that it is not suspected, and consequently not looked for.

In 1939, Sapero and Johnson[14] reported an incidence of 14.7 per cent infections with Endamoeba histolytica in men examined from the South as naval recruits at Norfolk, Va. Only 7.8 per cent of the men recruited from the North were found to be infected.

Widespread interest in Amebiasis in the United States did not develop until after the epidemic in Chicago during the World's Fair in 1933. At that time, there were over 800 cases with 40 deaths traced to two Chicago hotels. Careful study determined that defective water and sewage connections were responsible for the epidemic. It was in this epidemic that we phy-

sicians learned that the incubation period of Amebiasis could be as short as 7 or 8 days and as long as several months.

It is generally believed that only the cyst forms of Endamoeba histolytica are infective for man, and that the vegetative or trophozoite forms are destroyed by gastric secretions. However, Schwartzwelder[15] has succeeded in infecting dogs with vegetative forms alone. The vegetative forms when passed in the human feces die quickly on drying. The cysts, however, can survive for several weeks outside of the body if they are kept moist in water or in fecal masses.

TRANSMISSION

The disease is transmitted, according to Strong[16] in any one of four ways. The most common mode of transmission is through water or food, which has become contaminated with cysts from fecal material. It is also known that droppings of flies and cockroaches can transmit the disease. In some instances, epidemics have been traced to the use of human excrement in fertilizing vegetable gardens. It is also spread through lower animals, such as monkeys and rats.

When Endamoeba histolytica cysts are ingested into the human intestinal tract, they undergo development in the intestines and give rise to four small trophozoites. These may attach themselves to the epithelium of the crypts of the large intestine and some of them may penetrate through the mucosa into the sub-mucosa as a result of their ameboid movement and cytolytic action. In these areas, they create small abcess-like gelatinous structures, where the amoeba undergo development. These abscesses ultimately rupture, discharging some of their contents into the colon and form ulcers. In typical amoebic ulcers, the adges are undetermined.

In some cases, the ulcer is very deep and may lead to a perforation with subsequent peritonitis and adhesions. In some cases, the vegetative amoeba may migrate into the venous system and be carried to the liver, lung, spleen, brain or other areas. As time goes on, if the infection is restricted to the intestinal canal, there may be marked thickening of the walls of the gut with the formation of tumor-like masses. The most characteristic pathology of amebiasis restricted to the intestinal canal is formation of ulcers and thickening of the walls of the large intestine.

INCUBATION PERIOD

The incubation period, as pointed out previously, is exceedingly variable. It depends upon the susceptibility of the individual and the severity of the primary infection. It was proven during the Chicago epidemic that in some instances, the incubation period was as short as from 7 to 15 days while in others traced to the same source, the incubation period was as long as 77 days.

The symptoms of amebiasis are exceedingly variable and depend to a large extent upon whether the disease is limited to the intestinal canal or whether complications have developed. The most common clinical conditions associated with the term amebiasis is amoebic dysentery. The dysentery may vary from a mild diarrhea to an actual active dysentery. It is my opinion that by far the large majority of cases present only mild forms of diarrhea. Amebic dysentery is in truth what Mason-Bahr[17] has called "walking dysentery" as contrasted to bacillary dysentery, which he calls "lying down dysentery".

Remissions are quite characteristic of amoebic infections of the bowels. The patient may have looseness for 10 days or two weeks, and then may suffer from constipation, only to follow through with another bout of looseness. Some cases will have only two or three loose bowel movements in the morning, and others may have 12 or more movements daily. The stools usually contain dark-brown altered blood and have a peculiar penetrating odor. Sometimes there are gangrenous sloughs in the stools.

Abdominal tenderness may be present and it is usually more localized than is the case in bacillary dysentery. The tenderness when over the caecum may simulate appendicitis, when over the transverse colon it may simulate peptic ulcer, and when over the sigmoid may simulate diverticulitis. Unless there are ulcers in the rectum, there is usually very little straining or tenesmus. These patients usually have little or no fever, unless there are complications. They are not toxic and they do not have the rapid progressive emaciation seen so commonly in bacillary dysentery. Although, it is possible, there are relatively few cases with severe symptoms. Many cases have an enlarged palpable liver.

It has been my experience that intestinal amebiasis may not be accompanied in some instances by either diarrhea or dysentery, but that it may at times be manifested clinically by marked constipation with various types of intestinal pain. Many of these patients develop mental lassitude, neuroses, and some of them have what might be called "uncomfortable bellies" or "growling intestines". These are the patients that usually escape proper diagnosis, because stool examinations are not made.

COMPLICATIONS

The most common complications of amebiasis are amoebic hepatitis and hepatic abscess. This may occur at any time during the course of the infection. There is pain over the liver area with symptoms of toxemia, fever, enlarged liver and usually a considerable leucocytosis. Hepatic abscesses, when they develop are most commonly

seen in the upper and posterior portion of the right lobe. Such patients complain of weight and fullness in the liver area and may have stabbing pains over the hepatic area. Some of them have a dry cough with referred pains to the shoulder region. If the abscess is located in certain areas, swelling may be seen in the epigastric or the hypochondriac region. Such abscesses may rupture in many different directions, depending upon their location and surrounding structures. A typical amoebic abscess of the liver contains a chocolate-like or anchovy sauce type of pus.

Amoebic abscesses may occur in the lung, either secondary to liver abscesses or as primary lesions. They are occasionally seen in the brain, spleen, bladder wall, ovaries, uterine adnexa and even in the parotid gland. Amoebic appendicitis is occasionally seen in areas where the disease is common. It is worth a note of caution to the surgeon to point out that it is difficult to operate successfully on intestinal structures that are infiltrated as a result of amebiasis. Such intestines are fragile, do not heal readily and sometimes lead the patient into very great difficulty.

Turner and Beck[18] pointed out some of the clinical manifestations of Endamoeba histolytica in which the development of tumor masses in the large intestines could be easily mistaken for malignancies, rather than amebiasis on the basis of physical examination alone. As a matter of fact, the infiltration of the large intestinal wall and the tumor-like masses developing in a chronically infected large intestine may create a classical clinical picture of malignancy. In my own experience, this has happened sufficiently frequently so that I feel that a thorough stool examination should be made whenever malignancy of the lower bowel is suspected. I have been saved from serious embarrassment on several occasions by the simple expedient of careful stool examinations, finding that my patient had chronic amebiasis rather than a carcinoma. In such cases, it is much more satisfactory to clear them up with proper anti-amoebic treatment than it is to resort to surgery.

Endamoeba histolytica may also produce a serious dermatitis around discharging sinuses. This will respond to no ordinary form of dermatological treatment until its true nature is determined and adequate anti-amoebic therapy instituted.

DIAGNOSIS

The only positive way to diagnose amebiasis is to look for amoeba. The presence of cysts or vegetative forms of Endamoeba histolytica in the stool is positive confirmation. In my opinion, it is far more reliable than any other method. During recent years, a number of investigators have worked on complement fixation tests. Craig[19] used the serum of patients tested against alcoholic extracts of cultures of Endamoeba histolytica, and reported that a certain percentage of his patients known to be carriers of Endamoeba histolytica gave positive tests. Frye and Meleney[20] and later Meleney and McGath[21] investigated the complement fixation test for amebiasis and Meleney pointed out the many difficulties in obtaining proper antigens. Thus, at the present time, there is no short-cut to carefully repeated stool examinations for confirmation if amebiasis is suspected.

There are a number of therapeutic measures that may be used in the treatment of amoebic dysentery, but for the therapy of amebiasis in general, emetine hydrochloride is the drug of choice. While other substances used may be satisfactory for intestinal amebiasis, they do not compare with the results obtained by emetine hydrochloride when dealing with the various complications of amebiasis. We have also learned that a mixed treatment, where emetine hydrochloride is administered along with one of the amebicides, such as carbarsone, chiniofon, vioform or diodoquin, gives the best end results.

Although the Surgeon General's Circular Letter advises the use of emetine hydrochloride in doses of 0.06 grams (1 grain) daily from four to six days, I personally believe that the 10-day treatment is more satisfactory. The emetine hydrochloride should be given intramuscularly. It should be recalled that emetine hydrochloride may lower the blood pressure and may cause acute myocardial damage or peripheral neuritis when used improperly. It should never be given intravenously, and if the patient shows evidences of a toxic reaction, it may be necessary to discontinue the drug.

CONCURRENT DRUGS

Concurrently with the administration of emetine hydrochloride, any one of the following drugs may be utilized:

(1) Carbarsone, 0.25 grams (4 grains) by mouth three times daily for seven days. Toxic symptoms from carbarsone are quite rare, although occasional abdominal distress, nausea or vomiting or even dermatitis may occur.

(2) Carbarsone may be followed by a seven days' treatment with vioform. This drug is given in doses of 0.25 grams (4 grains) orally three times daily for seven days. There are practically no toxic symptoms from this medication.

(3) Instead of using vioform, diodoquin, 0.6 grams (9 grains) may be given orally three times daily for seven days.

(4) Chiniofon (Yatren) can be given in place of vioform or diodoquin. If this drug is used, the dosage is 1.0 grams (15 grains) orally three times daily for seven days. The only toxic symptom observed from the use of this latter drug is an occasional watery diarrhea.

When there are lesions in the lower colon or

rectum, carbarsone or chiniofon may be administered in the form of retention enemas concurrently with the use of emetine hydrochloride injections, and other medications by mouth. When used as a retention enema 2.0 grams (30 grains) of carbarsone are dissolved in 200 cc of a 2 per cent solution of sodium bicarbonate. This is given as a retention enema following a cleansing enema of 2 per cent sodium bicarbonate solution. If chiniofon is selected as the drug to be used for the retention enema 4.0 grams (60 grains) may be dissolved in 200 cc of water and administered after a cleansing enema. Sedation with one of the barbiturates will assist the patient in retaining these enemias. Neither vioform nor diodoquin can be used as a retention enema for they are relatively insoluble and are highly irritating to the mucosa when placed in the rectum.

The complications of amebiasis need energetic treatment. Amoebic hepatitis will respond in most instances to from 8 to 10 days' treatment with emetine hydrochloride, 0.06 grams (1 grain) administered intramuscularly daily. Amoebic abscesses of the liver should be drained by aspiration. Open surgical drainage should not be utilized. Emetine hydrochloride should be used in the same way for amoebic abscess as it is utilized in the treatment of hepatitis without abscess.

Carriers who have no symptoms may be treated with carbarsone, vioform or diodoquin. At the present time, the Army suggests the use of carbarsone 0.25 grams by mouth three times daily for seven days followed by vioform 0.25 grams three times daily for seven days, or diodoquin 0.6 grams by mouth three times daily for seven days. Again in the treatment of carriers, if neither vioform or diodoquin is available, one gram of chiniofon may be administered orally three times daily for seven days following the course of carbarsone.

B. Protozoal Dysenteries. (2) Other Intestinal Protozoal Dysenteries.

The protozoal ciliate Balantidium coli may also produce a picture clinically similar to amoebic dysentery. There is no particular geographic distribution of this parasite and it has been reported as the cause of dysentery cases in the United States, Central and South America, the Philippines, India, China, Siam, North Africa and throughout Europe.

Balantidium coli is commonly found in the intestine of the hog which is one of its natural hosts. The parasite is transferred in the encysted stage from hand to mouth in the handling of pig intestines. Numerous infections have been traced to eating raw sausages and over 25 per cent of the recorded cases have given history of direct contact with pig. The cysts are relatively resistant and even the handling of pig manure can be a source of infection.

The incubation period is variable. The onset of symptoms is insidious and quite similar to amoebic dysentery. There may be colicky pains, distended abdomen, anorexia, 8 to 15 stools from fluid to porridge consistency daily with marked emaciation and anemia in chronic cases. Cases vary in degree of symptomatology shown just as amoebic dysentery cases do.

Many treatments have been advocated but none are specific. Emetine is ineffectual in ordinary doses, but reports of prolonged use of 0.06 gm. daily for 15 to 20 days as observed in Tiflis have given better results. Such prolonged use of emetine is dangerous. Arsenical preparations have been tried with conflicting reports. In a recent group of 7 cases treated in South Carolina, Young[22] reports good results from the use of carbarsone. He administered 0.25 gm. bid for seven days in certain patients, and 0.5 gm. bid for 10 days in others. He has followed some of his cases as long as four years.

Dysentery in malaria occurs only in pernicious infections. In such cases the capillaries of the intestinal mucosa may become filled with malarial parasites. The intestinal mucosa becomes deeply congested, the stool blood-stained and full of mucous. The parasites and swollen endothelial cells of vessels may form thrombi and occlude the vessels. Cases have been reported where the diagnosis was just made by finding malarial parasites in the blood cells present in the stools. The treatment of this complication is the same as the treatment of pernicious malaria.

The visceral form of Leishmanial infection (Kala-azar) may be associated with a severe dysentery at times (25 per cent of cases). Such patients develop an intermittent fever (100-104°) with anemia, cachexia, enlarged liver and spleen and a prominent abdomen. The leishmania are present in the mucous membrane of the large and small intestine and polyps or masses with necrosis of epithelium and superficial ulcerations are produced. The epithelial covering of the villi is denuded and the stools contain blood and mucous. Left untreated about 90 per cent of these cases die. Since the use of Tartar Emetic and the subsequent development of the pentavalent antimony compounds, it has been possible to change the mortality of visceral leishmaniasis so that 90 per cent of patients recover if treatment is reasonably early and adequate. Intestinal coccidiosis is not very common and was first reported in soldiers from the Mediterranean area. Such patients have a diarrhea with liquid, brownish-yellow stools containing Charcot-Leyden crystals and undigested food. They complain of abdominal discomfort, flatulence, loss of weight and lassitude. Cysts are passed in the stools and can be identified readily for diagnosis. The treatment is non-specific.

C. Helminthous Dysenteries.

The most important of the Helminthous Dysenteries are the result of schistosomal infections. These occur throughout the Mediterranean Basin and in certain areas in the Far East. There are three types of schistosomal organisms, S. hematobium, S. mansoni, and S. japonicum. Depending upon the species of parasite involved, the eggs are discharged from human urine or feces into water where they hatch and allow a ciliated miracidium to escape. This small ciliated structure enters the body of a snail in which it develops into the cercarial stage. These cercariae later escape into the water and then may infect human beings through penetration of the skin or by oral ingestion.

It is not my purpose in this paper to discuss all of the symptoms which may be produced as a result of a schistosomal infection, but to point out the possible role the parasite may play in the production of dysentery. S. mansoni, S. japonicum and, at times, S. hematobium tend to lodge in the hemorrhoidal veins where they may produce polypoid growth which may resemble hemorrhoids in appearance, produce perineal fistulae, scarring and may result in producing symptoms simulating an amoebic dysentery or membraneous colitis. There are at least five different types of lesions of the colon that may result from schistosemal infections. In some individuals there may be a simple thickening of the mucous membrane, in others papillomata may form, in some, pericolonic tumors may develop, in others, polyps of the bowel may lead to intussusception, while in others, cauliflower growths may develop in the neighborhood of the anus.

The diagnosis of schistosomiasis is made on the basis of finding the typical eggs of the parasite in the stool or urine. Schistosomiasis responds to treatment with potassium or sodium antimony tartrate, Fouadin and other antimony preparations. The disease is prevented by avoiding infections in unpurified fresh water in areas where the disease is endemic.

The other helminthous dysenteries such as those caused by Oesophagostomum apiostomum, Echinostomiasis and Gastrodiscus hominis are rare conditions. It is entirely possible however, that these may be brought more forcibly to our attention because of the widespread distribution of our military personnel in parts of the world where these conditions occur.

D. Flagellate Diarrheas and Dysentries

It is questionable whether the flagellates themselves actually cause diarrhea and dysentery symptoms or whether they produce these symptoms when they are superimposed upon some other infection and aggravate whatever symtomatology is present. Individuals who have studied these conditions carefully are inclined to believe that the flagellates probably play a secondary role in the diarrheas.

The most common flagellates in the intestines are Giardia lamblia, Trichomonas, and Chilomastix. Giardia are more common in the tropics, but have a worldwide distribution. When they are present in large numbers, patients develop bowel looseness with 5 to 6 or more stools daily. There is relatively little colic or spasm, usually no tenesmus, but ordinarily a great deal of flatulence. The condition characteristically is associated with exacerbations and remissions. Giardia are frequently present in large numbers in diarrhea and dysentery due to other causes and undoubtedly aggravate the symptomatology.

Up to the present time, the treatment of the flagellate infections has remained relatively unsatisfactory. The arsenicals sometime give favorable results, chiniofon has been used in some cases, and recent reports indicate that atebrin is useful in some instances.

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What Is An Occupational Disease: Its Diagnosis, Management and Prevention

BEN ARNOFF, M.D.

ALTHOUGH many of the diseases which are considered as occupational diseases have been known to medical science for centuries, they are mere infants in the Workmen's Compensation Law. The law in Ohio began to recognize a relationship of disease to employment other than as a result of injury in 1921. At the time of the inception of the Occupational Disease Law, the diseases recognized were peculiarly limited to those which are listed by the legislators. Looking back over this list of legally recognized occupational diseases, we find that they comprised only a very small percentage of the known medical occupational diseases. This is borne out if we look at the figures of claims filed with the Industrial Commission since the effective date of the Occupational Disease Law. While it is true that there are other factors to be considered in evaluating these figures, I feel that there is a definite relationship between the number of cases filed and the inadequacy of the law.

You will note from the chart that from 1927 (which is the earliest year that figures are available) to 1937, the number of claims filed remained fairly constant between 1,000 and 1,500.

Of course, this figure does not indicate the number of these claims which were actually occupational diseases as defined by law. They merely represent the actual number of claims filed. The slight increase in the number of claims filed in 1937 can be accounted for by the inclusion of silicosis in the list of compensable occupational diseases.

Now, you will note that from 1939 to the present time, there is almost a vertical line from the usual less than 2,000 claims to the new high of over 7,000 claims in 1943. Obviously, we can account for a good many of these cases by the unprecedented increase in employment since 1941. But, you will notice that the curve started its upward swing in 1939. It was in 1939 that the so-called all-inclusive amendment was added to the Occupational Disease Law.

Looking at the figures in another way, we find that if the Occupational Disease Law which was in effect prior to 1939, was still in effect in 1943, we would have only approximately 70 per cent of these claims filed. The other 30 per cent of these occupational diseases would be barred by law.

The Author

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OCCUPATIONAL DISEASE?

We now come to the question: "What is an Occupational Disease?" At the onset, I wish to point out that there is a distinction between an occupational disease and a compensable occupational disease.

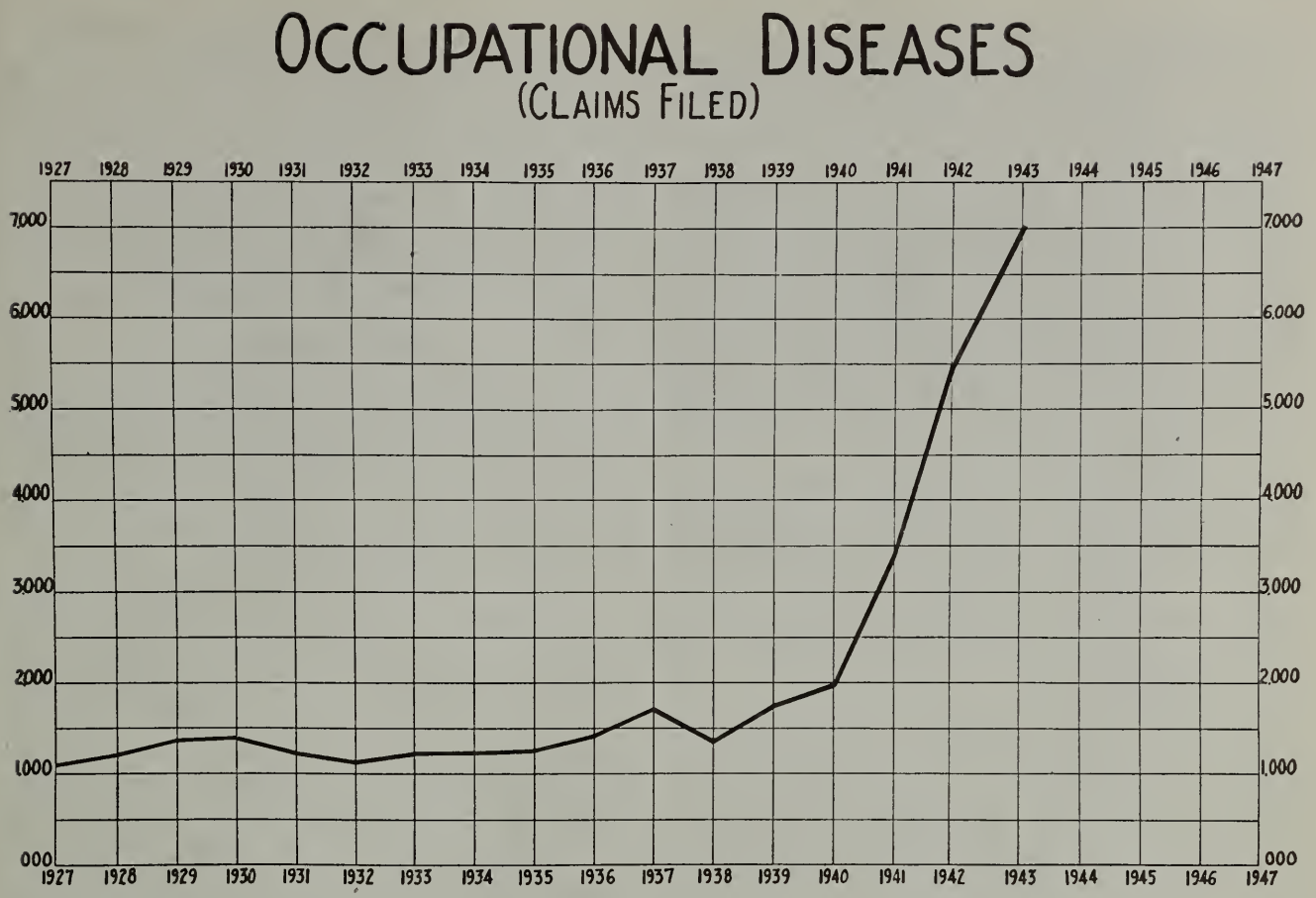
This is a fact which frequently is not appreciated by physician, attorney, employer or employe. If an individual is suffering from any one of the 22 enumerated diseases in the law, there is no question of the compensability. On the other hand, the difference between an occupational disease and a compensable occupational disease becomes manifest under Section 23 or the so-called "all-inclusive amendment". This section of the law reads, "a disease peculiar to a particular industrial process, trade or occupation and to which an employe is not ordinarily subjected or exposed outside of or away from his employment."

I do not intend to get into a legal discussion over interpretation of the law because I have no such qualifications. Furthermore, the attorneys themselves have not settled the question as yet of this medico-legal problem. I am limiting the discussion to the medical aspects, the medical implications and the medical problems created by this section.

There are two important phrases in this section: First, "a disease peculiar to a particular industrial process, trade or occupation"; and, secondly, "to which an employe is not ordinarily subjected outside of or away from his employment". In the first phrase, the all-important words are "peculiar to".

In order for a disease to be medically peculiar to an occupation, there must obviously be a prevalence of this disease in a given industrial process or trade. This does not mean that every

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person in this occupation must have the disease, but that there must be a significant percentage beyond the realm of coincidence. The disease should be found in a particular occupation and nowhere else.

A typical example of a truly compensable occupational disease is silicosis. Silicosis is only found among employes who are exposed to silicon dioxide. This disease is not found in any other occupation and can not be contracted outside of and away from employment. We also find a significant percentage of workers in this occupation who develop silicosis, beyond any doubt, as a result of his exposure during the course of his employment. This disease obviously, therefore, is peculiar to an individual's employment.

On the other hand, I wish to cite a case of an individual who had lost his right thumb by amputation as a result of an injury several years ago. He had only the usual handicap of an individual who had lost his right thumb. However, during the course of his employment in a war plant, it was necessary for him to crate war materials for shipment. Apparently not being adept with the use of his left hand to hold a hammer, he held the hammer between the index and middle fingers of his right hand. After a few days, he developed an infected blister on the inside of his index finger due to the peculiar way in which he was holding the hammer.

Obviously, the infected blister was a result of his occupation and just as obvious we never see a carpenter with a blister on the inner aspect of his right index finger due to hammering. We, therefore, have a condition which is due to the individual's work, but not peculiar to his employment.

The Commission ruled in this case that this blister was not peculiar to his occupation, but rather developed because of a peculiarity of the individual, and it, therefore, did not constitute a compensable occupational disease. We, therefore, have a differentiation between a disease peculiar to an occupation and a disease peculiar to an individual.

Now, for the second phrase of this section, "to which an employe is not ordinarily subjected or exposed outside of or away from his employment". In general, this portion of the law, together with the previous phrase, rules out all infectious and contagious diseases and the aggravation of an already pre-existing disease.

To illustrate: Last Fall, there were many cases of a contagious eye infection spreading in plants throughout the country. Individual cases may have been directly traceable to fellow workers. Claims in large numbers were filed alleging an occupational disease. While it may have been true that these infections were contracted at the place of employment, they were not considered compensable occupational diseases because eye infections were not a peculiarity of the type of work which was being performed.

Furthermore, these individuals may have contracted the infectious disease outside of and away from their employment by mingling with crowds in street-cars and buses, theaters, shopping centers, etc.

Tuberculosis is probably the most common infectious, contagious disease for which claims are being filed. It has been definitely proven that there are no industrial hazards which cause or predispose individuals to tuberculosis with the exception of silica. Here again, each one of us runs the hazard of exposure to tuberculosis, more so outside of and away from our employment than during the course of our work.

The common cold, influenza, bronchitis, and similar diseases are also infections to which we are more commonly exposed outside of and away from our employment rather than the phraseology of the law, "to which an employe is not ordinarily subjected outside of and away from his employment".

There are certain situations under which infectious and contagious diseases can be considered as compensable occupational diseases. Among doctors, nurses and employes of tuberculosis sanatoriums, the hazard of contracting tuberculosis is a peculiarity of the occupation, and there can be no argument that this class of employes certainly carry a greater exposure to tuberculosis during the course of their employment than outside of and away from their work.

AGGRAVATION

Aggravation of a pre-existing disease is recognized as an occupational disease, if the factors causing the aggravation are peculiar to a particular industrial process, trade or occupation and to which an employe is not ordinarily subjected outside of and away from his employment.

We have had many claims filed for an aggravation of a pre-existing heart disease. While it is true that an individual with heart disease, whether it be high blood pressure, rheumatic fever, or whatever the disease, working definitely aggravates the disease process. However, so does everything else the individual does. Merely getting out of bed and walking around, even though not gainfully employed, will aggravate the heart disease. The same with tuberculosis, unless confined to absolute bed-rest, the tuberculosis will be aggravated merely by being up and around.

An example of a compensable aggravation is an individual with an inactive tuberculosis who works in a silica hazard. It is a known medical fact that silica predisposes and re-alights an inactive tuberculosis. Therefore, if an individual develops active tuberculosis in a silica hazard, we consider this as an aggravation due to conditions peculiar to his employment, and to which he is not ordinarily subjected outside of and away from his employment.

A discussion of this section could go on practically indefinitely. I believe we can summarize by defining an occupational disease as a condition which is the result of repeated exposure or trauma, which is peculiar to an occupation, and to which an individual is not ordinarily exposed outside of and away from his employment.

THE DIAGNOSIS

Now getting on with the diagnosis of an occupational disease, I will not attempt to discuss any specific occupational disease because in a mixed group such as this, it would be boring to listen to a discussion of an occupational disease with which you are never confronted.

However, there are certain general principles which apply to the diagnosis of all occupational diseases. First, there must be an exposure, injurious in amount, to the substance which is suspected of being the offending agent.

As obviously simple as this fundamental principle appears, it is surprising how many times a diagnosis is made, when on investigation, it is found that no such exposure exists. Just within the last week, we have had one case reported as oil dermatitis, and another case reported as lead poisoning. Upon investigation, it was found that there was no oil exposure in the one case, and no lead exposure in the other case. I don't believe a week goes by that we don't have similar cases reported.

Such diagnoses are not fair to any of the parties concerned. It isn't fair to the employe because all too often he is told that he can never return to his regular trade because continual exposure will prevent him from getting well. Thus a man is deprived of his means of livelihood and it forces him to learn a new trade. Probably in the majority of cases, either because of age or educational background, such a change is practically impossible. It isn't fair to the employer because he loses a well trained and efficient employe, and his place of business is all too often condemned as an unsafe place to work, thus creating a serious labor problem.

ACCURATE DIAGNOSIS

Lastly, it isn't fair to the employer or the Industrial Commission to be asked to pay for something which does not exist. I believe that most of these inaccurate diagnoses are made in good faith. The trouble lies in the fact that the doctor obtains his information of working conditions and exposure solely from the employe who either bases his information on hearsay or his own personal opinions.

The remedy to this situation is relatively simple. If there were closer cooperation between

doctor and employer, if the doctor could know the working conditions and be acquainted with the materials used which are potentially hazardous by actually visiting the plant personally, he would have accurate scientific knowledge of the exposures, and would not have to rely on inaccurate and misleading information volunteered by the uninformed patient. This would obviously lead to better medical care for the employe, a greater service to the employer by returning a valuable man to work sooner, and a great financial saving to employe, employer and the state.

Secondly, before a diagnosis of an occupational disease can definitely be made, the symptoms and physical findings presented must be known to be caused by the substance to which the individual was exposed. If the patient is the only one so affected among many who are equally exposed to the same substance, the diagnosis of an occupational disease should not be made unless complete study and investigation proves without a doubt that an occupational disease is present.

Thirdly, the undisputed test of an occupational disease is that upon removal from the suspected offending substance, the individual improves or recovers, only to have an exacerbation of the same disease upon returning to the same exposure.

THE MANAGEMENT

The discussion of the management of occupational diseases will of necessity be limited to general principles which may be applied to the treatment and management of all occupational diseases.

The proper medical management of a disease depends, of course, on an accurate diagnosis. There are certain conditions which develop upon exposure to a new substance, but which soon clear up after a short period of time. This is frequently referred to as the "hardening" process. We commonly see this phenomenon in occupational dermatitis. However, if the disease continues or becomes worse, the individual should be removed from the exposure.

The removal from exposure is probably the most important single procedure in the proper management of an occupational disease. Upon removal, the disease should show prompt improvement if the proper diagnosis has been made. Return to work is another phase of the proper management of an occupational disease.

I wish to point out here that there is an important difference between "return to work" and "return to exposure". There are many occupational diseases which prevent a man from returning to the exposure of the offending substance responsible for his occupational disease, but yet his disease does not cause total or even partial disability for some other type of work. In other words, the individual is physically able to return to work that does not bring him into contact with the cause of his disease.

I believe that such return to work should be encouraged. There are many occupational diseases which will forever prevent the worker from returning to his trade. In these cases, competent rehabilitation should be started as early as possible for the good of both the worker's mental attitude and his financial status. The one phase of industrial health that can be adequately controlled and prevented is the occupational disease.

In the main, the contraction of an occupational disease by a worker is the signal that there is a controllable hazard which should be and most probably could be remedied. This remedy may depend on the installation of proper equipment by the plant, or it may be the proper education of the worker himself. The responsibility does not always lie with the employer, but frequently with the employe. The field of prevention, therefore, requires the close cooperation of the physician, safety engineer, employer, employe and frequently in modern day production, the cooperation of the industrial chemist.

PREVENTION

Preventive medicine can be applied and should be applied because all too frequently the disease process is permanent and irreversible. It would be so much easier to prevent a disease than to cause the death or permanent disability of a man.

Another phase of prevention is the pre-employment examination. By taking a careful history and doing a well-planned physical examination, many individuals could be found to be physically and constitutionally unfit for a particular job, and thus protect him from developing a disabling disease, death or a permanent disability.

Meningococcus Meningitis

Sulfadiazine and penicillin are both efficient therapeutic agents in the treatment of meningococcus meningitis. In the present series, two of the patients probably would have died if it had not been used. The disadvantages of penicillin are solely related to administration; it must be given intrathecally at least once a day, as well as intramuscularly every three hours, to be effective. As a result of our experiences, sulfadiazine is given first choice in the treatment of meningococcus meningitis and is begun as soon as possible. In the milder cases no other specific therapeutic agent seems necessary; but, in the very seriously ill and those who do not respond promptly to sulfadiazine, penicillin is used as a supplementary aid.—Drs. Stainsby, Foss and Drumheller, Danville, Pa.; Penn. Med. Jr., Vol. 48, No. 2, Nov., 1944.

Influenzal Meningitis

OLIVER W. HOSTERMAN, M.D.

TEN years ago the mortality rate of influenzal meningitis hovered around one hundred per cent. Today, through the use of two specific agents, namely, type specific rabbit antisera and sulfadiazine, the outlook has changed considerably. As a consequence of the discovery of the polysaccharide capsule of the organism and the subsequent division of the influenzal bacillus into six distinct types, designated as a, b, c, d, e, and f, rational therapy with type specific horse antisera and complement was begun. Even so, the mortality rates remained high, and little success was obtained until the introduction of the sulfonamides. Chemotherapy, either alone or in combination with specific horse antisera resulted in the publication of reports of case recoveries. However, the substantial drop in the death rate did not occur until Alexander[1] recommended the use of type specific rabbit antibody in conjunction with sulfadiazine.

During this ten-year period numerous articles have appeared in the literature dealing with the investigation and therapy of influenzal meningitis. Dr. Schwinger[2] of Cincinnati reviewed the greater portion of this work before the Ohio State Annual Meeting here in Columbus two years ago. Since that time the routine of therapy has been well standardized, mostly through the work of Alexander[3], and it becomes the duty of the medical profession at large to acquaint themselves with the recognition and the modern treatment of this disease. Hence I shall confine my discussion mostly to the clinical aspects involved.

Perhaps because of the increased interest and better diagnostic technique, the frequency of influenzal meningitis seems to be mounting. During some seasons it ranks second in frequency of all meningeal infections being surpassed only by meningococcus meningitis. It is distinctly a disease of infancy and childhood, the majority of cases occurring under two years of age. This is undoubtedly due to the loss of antibody shortly after the newborn period. This absence continues until three years of age at which time the antibody titre again rises steadily.

As the result of this absent protection and the associated difficulty in diagnosing the disease early in infancy we find that even with excellent therapy 75 per cent of the infants under seven months die from the disease. Contrast this with the mortality rate of 17 per cent over the seven-month period. Evidence suggests that the advanced stage of the disease in infants at the time therapy is started is responsible for this high death rate. Certainly the virulence of the organism is the same in both age groups and there seems to be no difficulty in the ability of the infants to utilize antibody. Therefore it appears that if we wish to reduce the mortality rate under seven months of age we must develop our diagnostic ability to a better degree.

Clinically, influenzal meningitis differs in no respect from the other pyogenic meningitic infections. It may display an acute fulminating picture identical with that seen in a meningococcus infection, except for the absence of petechiae, or the clinical course may have the features of a long drawn out tuberculous meningitis. Between these two extremes all varieties of infection may occur. In early infancy the detection of early meningeal involvement constitutes the chief problem.

The disease is generally ushered in by several days of unexplained fever, at times associated with a mild upper respiratory infection which might readily be ignored. The infant who displays drowsiness, alternating with irritability, should warn the examiner to pay particular attention to the fontanel tension. Experience enables one to detect an increase in intracranial pressure some time before the stiffness of the neck or the appearance of a Kernig sign. Unfortunately, at this point the meningitis is well advanced and the use of correct therapy may be of no avail.

If the fontanel is not open sufficiently to detect increased pressure one should rely upon the appearance of irritability, a high pitched cry and a staring of the eyes as an indication for a spinal tap. In other words any suspicion of meningeal involvement in association with unexplained fever warrants spinal fluid investigation. Only in this manner will one be able to find the early cases. In the older child drowsiness, de-

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lirium, hyperactive reflexes, nuchal rigidity with a positive Kernig and Brudzinski reflex demands an immediate spinal puncture. The ultimate diagnosis in either age group depends solely on the spinal fluid examination.

SPINAL FLUID

Influenzal meningitic spinal fluid differs little from that of the other pyogenic infections displaying a high cell count with a preponderance of polymorphonuclear cells, and a decrease in the sugar and chloride. So again the correct diagnosis must depend upon bacteriological and immunological identification of the organism involved.

The H. influenza organism is a pleomorphic gram negative bacillus producing a specific soluble polysaccharide which Pittman[4] demonstrated as responsible for its type specificity and pathogenicity. This specific soluable substance forms the capsule of the organism and in the course of metabolism this carbohydrate is excreted into the surrounding medium. It is the presence of this substance which greatly faciliates the identification of the organism. This is accomplished in two ways. First, by the use of type specific rabbit serum the bacillus may be identified by a swelling of the capsular component in the same manner as a Neufeld typing for pneumococcus. Second, the specific soluble substance of H. influenzae can be demonstrated in the supernatant of the spinal fluid by a precipitation test.

This test is performed in the following manner. Over a one centimeter column of the diagnostic typing serum in a small precipitin tube an equal column of the spinal fluid is carefully layered by means of a fine capillary pipette. A positive test consists in the formation of a white ring at the interface. The time involved for the appearance of the precipitate likewise serves as an index as to the severity of the infection, the shorter the interval, the more severe the infection.[3]

At times the spinal fluid may fail to reveal organism on the direct smear, but culture on blood or chocolate agar or in Levinthal broth should produce a good growth within 12 to 24 hours. In the same interval of time a second spinal puncture will often times release a turbid spinal fluid loaded with organism which can be readily identified.

In a high percentage of cases of this form of meningitis type b H. influenzae bacilli may be cultured from the nasopharynx and also directly from the blood stream.

By a study of the literature it is apparent that there are several methods used in the treatment of this form of meningitis. Success has been reported by the use of horse serum with complement, the use of rabbit serum, and the use of chemotherapy. However, all recent reports clearly demonstrate that the lowest mortality is obtained by the combined use of sulfadiazine and type special rabbit serum.

THERAPEUTIC PROGRAM

The outline of any therapeutic program must include the following details:

1. An ample supply of fluids must be furnished. This is advised on the theory that a considerable amount of specific soluble substance liberated by the organism is present in the tissues. By the use of a continuous intravenous infusion the urinary excretion of the carbohydrate is hastened. By this elimination of specific carbohydrate a given quantity of antibody is more effective if utilized mainly against the carbohydrate in the capsules of the organisms. Adequate fluids should likewise prevent the violent reactions at times encountered by the sudden union of large quantities of antibody and antigen.

2. Sufficient amounts of sulfadiazine should be administered to produce inhibition of the growth of the organism. By this inhibition further liberation of free carbohydrates into the tissues will be prevented. That chemotherapy is of value has been demonstrated by reports of recovery by this means alone. Alexander[5] in a recent report demonstrated that all the sulfonamides exert significant inhibitory effect against type b H. infiuenzae both in the test tube and in infected mice. She very conclusively proves that sulfadiazine is the drug of choice, being far more potent than all the others including sulfamerazine.

3. Adequate amounts of type specific rabbit serum must be administered, in quantities sufficient to maintain an excess for the expected period of therapy. In order to accomplish this some basis for the determination of the quantity necessary must be used. Alexander[1] has pointed out that the level of the spinal fluid sugar before treatment reflects the severity of the infection and the dosage of antibody should be given according to this level as outlined below.

Spinal Fluid Sugar (mgm. per cent)	Mgm. Antibody Nitrogen Indicated
below 15	100
15 to 25	75
25 to 40	50
over 40	25

To determine whether sufficient antisera has been given for recovery the presence of antibodies in the blood serum and spinal fluid can be determined by means of a capsular swelling reaction. A sample of the patient's blood serum when diluted 1:10 should cause capsular swelling of a suitable suspension of H. influenzae. Another method of determining the efficacy of therapy is the Francis[6] test which consists of the intracutaneous injection of 0.1 cc of 1:5000

dilution of type b H. influenzae polysaccharide. A positive reaction is indicated by the appearance of an immediate wheal and erythema at the site of injection indicating sufficient quantities of circulating antibody. Such evidence of antibody excess should be present throughout the course of therapy and should parallel the patient's clinical improvement. If at any time such evidence is lacking, an additional dosage of antibody should be given. Though intravenous injection of antisera is advised, it has been recently shown by Boisvert[7] that intramuscular administration is perhaps just as effective.

TREATMENT

The details of treatment for type b H. influenzae meningitis can be summarized as follows:

1. Sulfadiazine should be administered by means of a continuous intravenous infusion set. The dosage consists of 0.1 gram per kilogram per day, one-half of this dose given immediately.

2. Approximately 40 cc. per kilogram of fluids are given intravenously within the first four hours to speed up the urinary excretion of specific soluble substance.

3. At the end of this four-hour period the calculated dose of rabbit antibody diluted in saline equivalent to 10 c.c. per kilogram of the patient's body weight is added to the infusion, and the speed is adjusted so that the administration of the diluted antibody is completed within two hours.

4. Fluids should be continued intravenously or subcutaneously as indicated by the child's condition.

5. The daily determination for excess of antibody in the blood serum and spinal fluid should be done. If at any time such excess is not demonstrable additional antibody should be given intravenously, and if necessary, intrathecally.

6. Sulfadiazine may be given orally as soon as the patient's condition improves sufficiently to tolerate oral therapy. The dosage should be sufficient to maintain a blood level of 15 mgm. per cent, and should be continued until one or two weeks after the first sterile spinal fluid is obtained.

7. One should resort to the judicious use of blood transfusions, as blood itself exerts a certain bactericidal effect on the organism.

With such a therapeutic program one can look forward to a rather high survival rate in contrast to the hopeless outlook in the past. During recent months there seems to have been quite a rise in the incidence of influenzal meningitis resulting in a shortage of rabbit antisera as prepared commercially by E. R. Squibb & Sons.

Under such circumstances one should resort to the use of sulfadiazine, horse antisera and transfusions. Therapeutically rabbit type specific antibody has been found to be superior to horse antibody in the treatment of H influenzae meningitis. The smaller molecule of the rabbit serum which allows for greater permeability probably accounts for its superiority. Also rabbit serum seems to have no so-called prozone effect, that is, there appears to be no zone of inhibition of protection when an optimal maximal dose is exceeded such as occurs with the use of horse serum. Because of this superiority one should use rabbit serum whenever available.

At present penicillin seems to be of little value in the treatment of influenzal infections, but it is possible that some similar preparation or further advencement in chemotherapy may soon antiquate the above outlined program.

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Summary of Shock Treatment

1. Prevent its development.
2. Stop bleeding.
3. Relieve pain.
4. Avoid continued tissue damage by such measures as splinting of fractures, et cetera.
5. Maintain body temperature—prevent chilling—do not overheat.
6. Place in shock position, unless contraindicated.
7. Give sufficient whole blood, plasma, or serum as soon as possible.
8. Administer warm fluids as indicated.
9. Choose an anesthetic agent which will not aggravate the condition.
10. Do necessary surgery as quickly, and with as little tissue damage, as possible, but only after shock has been controlled.
11. Carefully observe the shocked patient postoperatively. Do not let him relapse into shock. Remember that the primary disturbance in shock is diminution in the effective circulating blood volume. Treat it by intravenous administration of blood, plasma, or serum—Robertson Ward, M.D., San Francisco; Calif. & Western Med., Vol. 61, No. 4, Oct., 1944.

Urolithiasis

VICTOR C. LAUGHLIN, M.D.

THE formation of urinary calculi in the great predonderance of cases, takes place in the kidney. Stones may migrate to the ureter, the bladder or urethra where they undergo further development, but the fact remains that most urinary calculi have their origin in the kidney itself.

Calcareous disease is truly a serious clinical entity and in every sense a serious disease. One third of all persons afflicted with renal or ureteral stones lose a kidney by reason of complicating pathology, by surgery or both. It is unfortunate that, frequently, the stone does not trouble the patient very much and consequently the patient in turn does not bother the stone.

Whenever a stone is discovered in the urinary tract it merits the proper attention of the physician. Stones when first formed are fortunately very tiny, and many, almost microscopic in size pass down the ureter to the bladder and are washed out in the uninary stream without the patient's knowledge. Stones of one to three millimeters in diameter usually cause so much pain that their host is acutely aware of their passage.

HISTORY

One of the oldest of afflictions, urinary stones, have plagued mankind for countless ages. The earliest known calculus was found in a mummy by Elliot Smith, the noted Egyptologist, estimated to be at least 7,000 years old.

The subject has been under study and controversy since the time of Hippocrates and Galen. Until 50 years ago bladder calculi were considered the most frequent type of calculus formation. The reasons for this are evident. Until then there was no way of recognizing stone in the kidney except for its more inportant symptomatology—pain and hematuria. If the patient was fortunate and the stone small enough, it would slide down the ureter to the bladder and if his fortune continued it would be washed out by the urinary stream.

In patients less fortunate the stone would remain in the kidney, ureter or bladder and there grow sometimes to enormous size. When his symptoms became unbearable the patient would seek the help of a physician and various concoctions to dissolve the stone would be prescribed, as is sometimes done even today. When such prescriptions failed and the symptoms became unbearable he was referred to the "Lithotmist," the ancient counterpart of the modern urologist.

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The ancient lithotomists were an interesting set. During the Middle Ages, they were wanderers traveling from city to city advertising by the town crier (not so different from today), that beginning in the morning they would "cut" all and sundry for stone. These itinerate lithotomists were men of little training. Some assumed the title of "Frere" and dressed as a monk of some order. Their ranks were often recruited from swine gelders and soldiers not afraid of blood. They were secretive with their methods often passing them down from father to son even to the fifth generation as in the case of the Tolets.

During the Middle Ages the operations performed were always for stone in the bladder. The patients, or perhaps more properly the victim, was securely held by three or more assistants (he didn't like it either), one of which sat astride the patient's chest (a form of anesthesia). The other two assistants held the arms and legs. There was no other anesthesia besides a little opium and wine, usually a lot of wine.

The surgeon selected his spot in the perineum and plunged in a knife and with his finger began to fish. Surprisingly, the skilful lithotomist could complete his operation in from one to two minutes.

Many famous men suffered from stone (as they did from venereal disease but that's another story). They suffered from the after-effects of the lithotomy technique, too, of course. Old Dr. Pepys of diary fame had a stone in his bladder when quite young and was "cut" for stone. He had a beautiful case made in which to preserve the specimen. He also celebrated the anniversary of his event by calling in his friends for a great feast. After his death the postmortem showed his left kidney to be filled with stones. Now-a-days when urolithiasis affects really important people the government sometimes takes a hand. In the old days this was also true.

Joanna Stevens invented a "remedy" which she claimed would dissolve stones. So popular did this remedy become that we actually have recorded the spectacle of that august and erudite body, the British Parliament falling for such a hoax and by an act of Parliament purchased the fraud from this female imposter for the sum of 5,000 pounds ($25,000.00). For the "good of the public" this formula was published in the *London Gazette*, June 17, 1739. Its contents were a shocking array of arrant nonsense. As published the prescription consisted of powdered old clay pipe stems, eggshells, snail shells, soap, white onions, sassafras, burdock seed, hips and haws and a few other common vegetable extracts. As fine a prescription to make stones as one could imagine. The general population used it assiduously, as they do advertised nostrums today. Even some of the medical men, not only endorsed it, they took it themselves.

Sir Thomas Sydenham, spoken of as "The English Hippocrates" not only took Joanna Stevens remedy so dearly bought, he recommended it. Cheselden, the first of the surgeon lithotomists, also is said to have recommended its use.

The best surgeons of the day were still doing "lateral lithotomies" by the perineal approach, no longer than 60 years ago. All that we know about urolithiasis has been learned in the past 50 years. Thus, in the light of history and the knowledge of the past half century, what have we learned?

ETIOLOGY

At the turn of the century Joaquin Albarran (Cuban surgeon in Paris 1860-1912) divided urinary calculi into two classifications:

(1) Primary—formed in clear urine in the absence of infection.

(2) Secondary—formed secondary to infections.

This remains as a good but insufficient classification. The composition of urinary stones is well known and since they spring from urinary sediment they may contain any or all of its elements. The various salts of magnesium and calcium in combination with uric acid, phosphorous and oxalic acid, composed the greater number. Just what starts the chemical process and results in the formation of a stone is not entirely clear.

Opinions vary on minor points regarding the etiology of urinary calculi but upon the broader principles there is general accord. Certainly there are immediate and predisposing causes.

By immediate is meant the deposit of urinary crystals upon some object which serves as a nucleus. This may take place in a tubule, on a papilla or upon the walls of the renal pelvis. Foreign bodies, blood clots, tissue fragments, mucous, pus or micro-organisms are numbered among such objects.

Predisposing causes may include over eating nitrogenous or carbohydrated foods, the too free use of wine and liquors, low water intake, vitamin imbalance, infections, abnormal positions of the kidney, obstructions of the urinary stream, constitutional phosphaturia and cystinuria.

Urolithiasis is more common in males, and of males and females of all ages it is more noticeable between 20 and 50.

The recent succinct discussion of the etiology and treatment of uninary calculi by Doherty* has been most illuminating. We have taken the liberty to include what this author has to say in our discussion of the subject.

A theory has been put forward that the nucleus of the stone is produced by incrustation on a primary septic or aseptic ulcerative process in a renal papilla, arising from infection or from trophic or allergic disturbances. The nucleus is therefore, adherent to the papilla to start with and later becomes free in the renal pelvis. Whether we accept this view or not the next point is to consider the factors which lead to the ulcerative or other methods of nucleus formation. These can be divided into two main groups:

(1) Factors outside the urinary system.

(2) Factors confined to the urinary system.

FACTORS OUTSIDE THE URINARY SYSTEM

(a) Geographic—It is well known that in certain districts stone formation is common. Water intake and diet are chief among the several factors held responsible in these districts. In hot climates, where there is much fluid loss through the skin and the urine is therefore concentrated, calculi are more common.

(b) Diet—The vitamin content of the diet is an important factor. It would also appear that a varied diet rich in proteins is better than a carbohydrate or vegetarian diet.

(c) Bone lesions—In a number of orthopoedic cases and in lesions of bone where there is much calcium reabsorption, especially when associated with prolonged immobilization, the heavy excretion of calcium phosphate and the usually low fluid intake predispose to urolithiasis.

(d) Hyperthyroidism and hyperparathyrodism —Such abnormalities may be factors. The greatly increased concentration of calcium in the urine associated with hyperparathyrodism is liable to result in the deposit of calcium phosphate stones in the urinary tract.

(e) Familial or constitutional tendencies—The condition has not infrequently been observed in succeeding generations of the same family. The

*Doherty, W. D.—Practitioner,—151:341 (December 1943).

nervous, dyspeptic, with lassitude, irritability and sedentary existence seems predisposed. Peptic ulcer is frequently seen in patients who have renal calculi. Individuals who perspire freely and whose skin is always moist seldom drink sufficient fluid to compensate for this loss. Cystine stones, and cystinuria frequently result from metabolic errors.

FACTORS CONFINED TO THE URINARY SYSTEM

(a) Stasis—stasis of the urinary stream may result from a variety of causes but the effects are the same, poor drainage; stagnation of urine; increased concentration of urinary salts; precipitation of these salts out of solution. Small particles thus formed and not properly washed away, remain and may form the nucleus of a large calculus.

Stasis may be the result of any congenital or acquired lesion in the upper or lower urinary tract. The pathological process of such lesion may be simple or extensive, it matters not. Drainage is impaired and urolithiasis may result.

Among the obstructive lesions may be a simple narrowing of one or more calyces leading to the renal pelvis, a stricture of the ureter, congenital or acquired, or a neoplasm of this organ, a ureterocele, bladder growths, vesicle neck obstructions, etc., etc.

In the lower urinary tract obstructive lesions of the urethra, prostatic pathology, congenital valves, etc., may give rise to residual urine, distended bladder, hydroureter, hydronephrosis (obstructive pyelectasis) and urinary stasis. The stasis which results from paralyzed bladder due to injury or disease of the spinal cord must also be mentioned. In all of these lesions the same factors are at work.

(b) Infection—an important cause of the deposition of calcium phosphate in the urinary tract. Many organisms have the effect of changing the reaction of the urine to the alkaline side and this is particularly true of the urea splitting organisms of the proteus group.

Infection is not a common accompaniment of a great majority of renal calculi particularly in the early stages of the disease when the urine is generally sterile. Often it is superimposed later. It is however a primary cause of stone formation in a number of cases. Bacteria and the products of inflammation themselves may form the nuclei of stones.

Infection may manifest itself as a pyelonephritis. Nephrolithiasis is frequently seen following the unresolved pyelonephritis of pregnancy. In chronic tuberculous pyelonephritis also calcium salts are commonly developed. Salpingitis and cervicitis in the female and chronic prostatitis and vesiculitis in males are foci which may lead to infection of the urinary tract and possibly to stone formations. There are many other such foci—infections of the teeth certainly should be mentioned.

PATHOLOGY

Much of the underlying predisposing pathology of urolithiasis has already been alluded to under the heading of etiology. Long recitations of minute pathological changes are seldom interesting except to pathologists. It only remains then to summarize briefly and emphasize the more important changes the kidney undergoes when calculi exists. The degree to which the changes take place depends upon several factors, the more important of which are the size, shape and composition of the stone; its location; the degree of obstruction which it causes and the presence or absence of infection.

Absence of infection—irritation of the kidney pelvis; congestion and later fibrous thickening of its walls; an aseptic pyelitis followed by a secondary nephritis (pyelonephritis).

Presence of infection—pyelitis (pyonephrosis) which is a short lasting, transitory lesion progressing more or less rapidly into a pyelonephritis, a stage in the pathological process wherein there is added to the pyelitis an involvement of that portion of the kidney substance proximal to the pelvis (pyelonephrosis) and characterized on the pyelograms by a blunting of the terminal irregularities of the minor calices. If not interrupted the process may extend to the renal parenchyma, multiple abscesses develop, work their way to the cortex and eventuate in perinephritis or perinephritic abscess.

The urologist thinks of pyelitis as the pathologist does but more particularly he qualifies it as being an abnormal distention of the renal pelvis (Pyelectasis), a condition in which the estimated capacity of the true pelvis* is greater than the estimated combined capacities of all the calices taken together. More correctly he speaks of this as being an obstructive pyelectasis rather than a pyelitis.

With obstruction the pathological changes are in order of development:

(1) Pyelitis (obstructive pyelectasis).

(2) Pyleonephritis—inflammation of the pelvis and proximal portion of the kidney.

(3) Pyelonephrosis (pyonephrosis) presence of pus in the pelvis possibly progressing to carbuncle.

(4) Perinephritis—Inflammation of the perinephrium, the envelop of Gerota and other pararenal tissues.

(5) Perinephritic abscess—finally.

The change taking place in the ureter and bladder are similar—ureteritis, ureterectasis or

*That portion of the pelvis which is left after an imaginary line is drawn through each isthmus of the major calices.

distention of the ureter above the stone, and in the bladder; cystitis, contraction and thickening of the walls. When the stone is located at the outlet of the bladder or below, distention, trabeculation, sacculation and diverticulation. In the presence of calculi the lining mucosa is inflammed, often ulcerated.

SYMPTOMATOLOGY

The symptomatology of this condition is well known. Often there are no subjective symptoms, "Silent calculi". The severity of the symptoms bears no reliable relationship to the size of the stone. Large calculi may cause the patient no distress whatsoever and small calculi may precipitate extreme agony. The reverse may also be true.

When symptoms do exist—**pain** is probably the most important and constant symptom. In the kidney it is usually of a dull aching character. If it radiates it usually follows the downward course of the urinary tract ending into the genitalia. The renal or ureteral colic characteristic of a moving stone is well known and needs no further elucidation. The reflex gastro-intestinal symptom are sufficiently important to bear mention. Chief among these are nausea and vomiting.

Hematuria—is the second most important symptom. Second because it is common to so many urological lesions. It may be micro or macroscopic, slight or severe, constant or intermittent.

"Gravel"—the passage of small calculi, usually not over 8-10 mm. in diameter may suggest the presence of urinary stone to the patient.

Renal Colic—Not all patients with urinary stone develop this condition. The picture of a patient in the agony of an attack of renal colic is one that should be stamped in the memory of every physician and nurse. It is different from amost any other paroxysm of pain seen. Certain factors seem to predispose the patient to attack; among these are sedentary habits, overeating and underexercising, spurts of vigorous strenous exertion, and the change from inactive to active life. There is no warning, suddenly and usually just after arising in the morning, the patient is seized with a paroxysm of pain so severe and agonizing that he seeks to better his position by tearing at his affected side, twisting constantly and rolling from side to side. Morphine is frequently ineffective.

The pain of renal colic never radiates upward. At times the whole of the affected side will become rigid and tender. The patient usually has a normal or sub-normal temperature during the attack and is pale and covered with a cold clammy perspiration. He has circumoral pallor. His feet and hands are cold, the pulse thready and rapid, usually around 100, he feels quite ill, retches even if he does not vomit although vomiting is often an accompaniment. One may be misled into thinking there is an intra-abdominal lesion.

DIAGNOSIS

Most urinary calculi are not difficult to diagnose provided the examiner keeps urolithiasis in mind when considering the eitology of abdominal pain. A very large percentage of patients presenting themselves to the urologist for relief of chronic abdominal distress bear the scars of previous abdominal operations. The diagnosis is based principally upon the history, the character of the pain, urinary findings, cystoscopy and pyelography.

Opaque calculi are readily identified by X-ray but non-opaque calculi are considerably more difficult to identify until they have been placed upon opaque backgrounds by special retrograde pyelographic procedures.

The examiner must keep in mind too the reflex gastro-intestinal symptoms which accompany a large percentage of chronic lesions of the upper urinary tract and remember that the urine analysis may be entirely normal for the patient with a complete block of one ureter.

TREATMENT

Treatment may be conveniently divided as follows:

A. Preventive (prophylactic or medical):
   1. Diet—High vitamin—acid or alkaline ash (dietary or chemical control of the hydrogen-ion concentration).
   2. Urinary antiseptic — antispasmotic — sedatives.
   3. Distilled water.

B. Instrumental:
   1. Dilatation of the ureter.
   2. Incision of the ureteral orifices.
   3. Various stone extractors.
   4. Injections of lubricants above the stone.

C. Operative:
   1. Choice of procedure depends upon many factors:
      a. Location.
      b. Size, shape, multiplicity.
      c. Destructive changes in the kidney.
      d. Condition of the opposite kidney.
      e. Operability of the patient.
      f. Previous stone history.
      g. Etc., etc.

SPECIAL CONSIDERATIONS IN REGARD TO TREATMENT

1. Renal stones precipitate symptoms by reason of the obstruction which they cause. They increase in size, exert pressure on the renal substance, and ischemia and atrophy results. Whether giving rise to symptoms or not the stone is a perpetual menace and surgical treatment must always be carefully considered.

2. The passage of a small calculus which has precipitated an attack of renal colic is not sufficient to consider the case completed. The reason

for the formation of the calculus must be discovered and corrected.

3. A normal urine does not preclude the absence of urinary pathology—the specimen may be from one side only.

4. Stones in the kidney considered passable through the ureter call for treatment which will promote their motility, engagement and passage; large quantities of water, physical activity, special postures, special exercises, etc.

5. Should surgery be attempted for multiple stones of the renal pelvis, it is imperative that all, even the smallest of these stones be removed. Otherwise a nucleus is left which will give rise to subsequent difficulties.

6. Staghorn calculi which may fill the renal pelvis are frequently symptomless until infection is superimposed. If the opposite kidney is sound nephrectomy is usually the operation of choice.

7. Bilateral renal calculi call for experienced surgical judgment. Usually the worst kidney is attacked first. It may then help relieve the strain when the better organ is explored.

8. Ureteral stones pause usually at one of three points of physiological constriction; at the uretero-pelvic junction, at the sacro-iliac synchondrosis or at the juxta-vesicle portion where the ureter transgresses the bladder mascularis The latter is the most difficult for treatment.

9. If the ureteral stone is large and not likely to pass the constricted lower portion it is wiser not to promote further descent and surgically remove it from the upper ureter.

10. Stones in the lower segment of the ureter can frequently be recovered by cystoscopic instrumental procedures; multiple catheters, stone extractors, orifice incision or dilation combined with antispasmotic medication.

11. Stones in the bladder may be the first evidence of urinary tract obstruction—such lesions must be corrected. Such stones may be crushed and the fragments removed or eliminated by open operation.

12. Solutions of citric acid, magnesium oxide and sodium carbonate have been used successfully for dissolving phosphatic calculi. The elaborate equipment, the economic factor incident to prolonged hospitalization or home care have deterred popularity for this method.

POSTOPERATIVE CARE

The stone will first be analyzed and at an appropriate time the urinary tract will be examined to eliminate the factor or factors responsible for its formation. Usually this will be found to be an obstructive or inflamatory lesion or both.

Chemical analysis reveals that the most common stones found are calcium oxalate, calcium phosphate, calcium urate, uric acid and cystine.

Calcium oxalate is a constituent of normal urine, nature's method of excreting oxalic acid from the blood. Oxalic acid (oxaluric acid) is a by product of metabolism but also oxalic acid is a constituent of practically all fruits and vegetables. Vegetables are the chief source of calcium oxalate in urine. All oxalic acid containing substances can not be excluded but an effort should be made to reduce them to a minimum. Measures mentioned under etiology to combat metabolic and constitutional tendencies must be instituted.

Calcium phosphate stones may occur pure or as deposits on a nucleus of any sort but only in the presence of persistently alkaline urine. Provided metabolic disorder can be ruled out it is an indication of urinary infection. In such cases all foci of infection must be eradicated (prostate, seminal vesicles, epididymis—cervix, follopian tubes—teeth, sinuses, tonsils—appendix, gall bladder and G. I. tract). Attempts to control the hydrogen-ion concentration of the urine should be made by diet or chemicals but are frequently disappointing.

The same general methods apply to the treatment of calcium urate, uric acid and cystine calculi except that in such case, through a proper regulation of the diet, the blood uric acid and cystine must be reduced.

Malignant Neutropenia

The disease most commonly affects females in the middle or later decades of life and is usually found in Caucasians, although cases have been reported in the colored race and then only in patients undergoing arsphenamine therapy. Kracke claims that it is found eight times more frequently in the "medical group"—physicians, dentists, nurses, and hospital employees—than in any other type of employment group. The reason for this incidence is possibly self-medication with offending drugs.

The onset of the disease is usually quite abrupt with lassitude, weakness, and fatigue. The temperature gradually rises, and in some to extreme pyrexia. Associated with these symptoms is redness of the throat leading to ulceration, which may be on both pharynx and tonsils. In some persons there is a severe and widespread infection with destruction of tissue in the throat. A severe headache is usually present and other bone aches may simulate an attack of influenza. The throat lesion may soon become gangrenous with a very foul oral odor present. Other areas of the body may show focal evidence of infection, such as the mucosa of the vagina, rectum, and stomach, and foci of necrosis may appear in the bone marrow. Drainage from these areas results in lymphadenopathy or lymphadenitis, and the glands are sensitive. Those about the neck are usually involved.—Charles B. Reitz, M.D., Allentown, Pa.; Penn. Med. Jr., Vol. 48, No. 2, Nov., 1944.

Dentistry in Pediatrics

L. S. PETTIT, D.D.S.

AFTER consideration of the material that might be used in this paper, I have decided to call your attention briefly to a number of factors pertaining to dentistry in pediatrics rather than to discuss in detail any one phase.

DENTAL CARIES

Let us first consider dental caries or tooth decay since it is the most common disease affecting the teeth and occurs in over 95 per cent of the civilized population. About 50 per cent of children have some decay by the time they are 2 years old. Decay is present in about 80 per cent of 3 year olds, about 90 per cent of 4 year olds and about 96 per cent of 5 year olds.[1]

In contrast to most diseases, it has become more prevalent with the advancement of civilization. Primarily, dental decay is caused by acid-forming bacteria acting upon carbohydrate food material, producing an acid that dissolves the mineral content of the tooth with resultant cavity formation. It should be mentioned here that tooth structures differs from any other tissues of the body in that the enamel of the tooth is so highly mineralized that it does not have a blood supply. So, when attacked by destructive forces it does not, like other tissues or organs, benefit by a defensive reaction. Thus it is evident that the tooth has no mechanism by which it can either protect itself from attack or by which it can repair injuries.[2]

Another factor one should consider in relation to dental caries is that of diet. Adequate nutrition is most essential during the developmental period for sound, well-formed teeth. But diet does not assure one of freedom from dental decay. It is a known fact that decay may be reduced and in some instances eliminated by a reduction of carbohydrate material such as sugar and flour from the diet. It should be carefully noted that this reduction in incidence of caries results from a local environmental change in the flora of the mouth rather than from a systemic reaction through the circulation. Therefore since there is no specific preventative for dental decay such as a vaccine, it is imperative that the cavity be filled so that the destructive process does not reach the nerve causing infection and subsequent loss of the tooth.

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FAULTY DEVELOPMENT

Developing teeth may be readily affected by disturbances in calcium metabolism. Hypovitaminoses, syphilis, exanthematous fevers, flourosis and other conditions may leave blemishes upon the teeth which are indicative of the portion of the tooth developing when the disease process is active.[3] Schour has demonstrated the "neonatal ring" in the enamel and dentin which represents a metabolic disturbance during adjustment to the extra-uterine environment by the new born.[4] From such disturbances mentioned some of the various forms of hypoplasia of the teeth have their origin. It should be kept clearly in mind that the crowns of the first set of teeth begin to calcify about the fifth month in utero and are completed approximately the first year after birth; while the second dentition begins to calcify at birth or shortly thereafter and the crowns are completed at the seventh to eighth year with the exception of the third molar teeth.

Relevant to the subjects of tooth development and dental caries there seems to be some confusion as to the effect of nutrition upon the same. Suffice it to state here that if nutrition is adequate for proper bodily growth and development and general health, there should be ample essentials present for proper development of the teeth. It has been suggested that feeding Vitamin D and calcium will prevent dental caries but I am sure all of you in this group have been protecting your patients with the essentials of nutrition and yet in many cases are astounded at the extensive caries present in many of the mouths.

In regard to this the Council on Dental Therapeutics has approved the statement that "All the calcium and phosphorous requirements for average needs, including pregnancy and growth, may be suitably obtained by means of an adequate diet containing not only calcium and phos-

phorous compounds, but also other necessary factors such as caloric requirements, protein and other mineral and vitamin requirements." Further it is stated by the Council that there is no positive evidence that the ingestion of calcium-phosphorous combinations in addition to diets adequate in these elements promotes the development of sound teeth in the human fetus.[5]

FLUORINE

Another phase of interest relative to the subject of dental caries is the action of fluorine compounds. Casual reference has been made earlier in this paper to the action of fluorine upon the teeth and there has been some publicity in current lay magazines. Perhaps there is no one subject in the dental field being more intensively investigated at the present time. For a number of years it has been observed that besides causing mottling of the enamels, fluorine in drinking water in some way contributed to a reduction of dental decay.

Investigations in this field have shown that amounts of fluorine less than those which cause mottling of the enamel would cause a significant reduction in caries activity. Amounts greater than one to two parts per million in the drinking water is likely to cause mottlng of the enamel. Carefully controlled experiments have shown that it has been possible to reduce the incidence of caries by local application of a medicament containing fluorine.[6] This type of procedure is naturally somewhat limited at present because of the toxic nature of fluorine. It seems quite possible that preventive means may be developed both by the control of drinking water and by the judicious use of fluorine containing substances in dental practice.

GROWTH OF TEETH

Now let's consider briefly growth and development of the teeth and face, a knowledge of which is important because of problems in diagnosis and prognosis. Without a knowledge of these physiological principles, it is often impossible to give proper advice. For instance, frequently about 4-6 years of age the anterior teeth begin to spread apart with very noticeable spaces between them. When first noticed by the parent, this separation causes considerable concern. However, it is just one of the normal stages wherein the jaws are enlarging to accommodate the developing second teeth that are much larger. Again frequently the permanent incisor teeth begin to erupt lingually before the first incisors are lost, and the dentist is asked to extract the baby teeth immediately which may be the wrong procedure at that time since the pressure of one tooth against another may help stimulate jaw growth.

On the other hand there are times when too long retention of teeth may cause malocclusions which might be very simply averted by the dentist seeing the patient at the proper time. There are times when the face and teeth seem to be quite out of proportion and harmony, particularly when the large adult teeth make their appearance in a child face. However, in normal cases as further growth and development of the remainder of the face continues, this lack of symmetry is lost. It should be understood that certain irregularities and malocclusions may be prevented or corrected simply by early care whereas delay may necessitate complicated treatment.

BROKEN TEETH

Another condition which pediatricians encounter quite frequently is that of fractured anterior teeth. This is particularly disturbing to both the parent and the dentist as well as the patient. These fractures are usually the result of traumatic injury and may vary from a slight abrasion of the enamel to complete loss of the tooth. Often the deciduous teeth are fractured at an early age as a result of a fall when the youngster is unsteady on his feet or a fall while at play. The tooth or teeth may be barely loosened or they may be forced into the tissues out of sight.

Treatment varies with the case but I believe it is wise to be quite conservative and try to retain the teeth and I have seen some remarkable recoveries. Frequently these teeth may become discolored but if the X-ray appears satisfactory and there is no evidence of infection they may be retained with frequent observation. If the tooth is infected and attempts to remove all infection fails, the tooth has no place in the mouth. When the permanent anterior teeth are injured there are more complicating factors involved. It may be that the root is not completely formed and if the tooth has to be lost for any reason there is the question of retention of space and the restoring of esthetics if the patient has reached the stage where pride demands much. The best insurance for satisfatcory treatment of these cases is that they be seen as soon after the occurrence of the injury as possible.

HABITS

Finally, let us briefly consider the question of habits that have an unfavorable influence upon the teeth and dental arches. The principal dental and facial deforming habits are thumb-sucking, lip and tongue biting and mouth-breathing.[7]

Thumb-sucking is the most common and is characterized by a labial displacement of the maxillary anterior teeth and the lingual displacement of the corresponding mandibular teeth. A variation of this habit is sometimes seen where the child engages the bridge of the nose with

the index finger which instead of depressing the lower anterior, permits them to become elongated in position. One or more of the fingers may be sucked with varying degrees of deformity resulting.

Lip biting produces much the same type of deformity as thumb-sucking and is caused by placing the lower lip between the upper and lower incisors and with a sucking movement forcing it forward. In tongue biting the resultant deformity is quite similar although the inclination of the maxillary teeth is not so great but the presence of the tongue between the teeth may cause a depression of the lower teeth and gives the appearance of an "open bite" since there is a very noticeable vertical space between the anterior teeth when the posterior teeth are in occlusion.

Mouth-breathing may be a cause of malocclusion and is usually caused by nasal obstruction such as adenoids. This habit is best corrected by removal of the obstruction with proper orthodontic treatment to correct the malocclusion. Various authorities suggest different types and methods of treatment of these habits but like other problems one finds that some respond to one treatment whereas it is inadequate for the same disturbance in another individual.

OTHER CONDITIONS

Many other things as supernumerary teeth, "submerged" teeth, ectopic eruptions of teeth and dental problems in diabetic cases might be discussed but time will not permit. I only hope I have been able to point out a few instances where pediodontia and pediatrics can cooperate for the benefit of the patient.

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Ten years have passed since Meulengracht published his first results on the medical treatment of bleeding peptic ulcer. The almost universal adoption of the prompt feeding program confirms his observations.—Joseph Shaiken, M.D., Milwaukee; Wisc. Med. Jr., Vol. 43, No. 11, Nov., 1944.

KEEPING UP WITH MEDICINE

EXPERIENCES at Sinai Hospital in Baltimore, based upon 150 regular deliveries whose mothers were allowed up on the third or fourth day and sent home on the sixth to the eighth day post partum, seem to show that they felt well, were able to care for themselves, and were much better equipped to go about their duties of caring for themselves and their newborn infants.

* * *

MOST of us city folks are coming to the season of the year when we shall breathe air that is drier than that of the desert. The continual inhalation of that dry air produces a profound drying effect upon the mucous membrane producing fissures and cracks. The ciliated epithelium is at first inhibited and if exposed for some time it is actually killed. Once these cilia have been destroyed, regeneration of the cilia epithelium is a long and tedious process.

The drying and fissuring of the mucosa, together with the destruction of the cilia, permit virus and bacteria invasion with the subsequent infection and in the allergic it makes absorption of the offending allergen so much easier.

* * *

MUCH too much of the energy units consumed by children is overrefined carbohydrates: Sugar, white flour, candy, and sugar water carbonated beverages. These foods contain no vitamins and few minerals but they greatly increase the need for vitamins. Children are constantly urged to eat vegetables, whether they have been depleted of their important vitamins makes no difference. The child must have his vegetables. Of course properly served vegetables are important, but by themselves they offer an inadequate supply of protein for the child's body and must be supplemented, if not by meat, certainly by milk, cheese and eggs. Candy, "pop" and the various herb carbonated drinks are a major preference in the diet of too many children. They contain no vitamins or minerals and yet, as has been said, they increase the need for the food accessories. Furthermore, they spoil the child's appetite for the plainer foods that do contain their own vitamins and minerals.

* * *

WHEN proper topical treatment is applied to the skin and a good elimination diet is employed, a soybean food, according to Stoesser of Minnesota, does help in eczema of infants and children both in the milk sensitive patient and in the multiple food sensitivity patient.—J. F.

Use of Curare in Anesthesia

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CURARE has been used sporadically in clinical medicine since the 19th Century for the control of muscular spasms and convulsions.[1,2,3] In recent years it has been used in the treatment of certain neurological diseases.[4,5] The latest development has been the use of curare during anesthesia to provide muscular relaxation. The present interest in curare was made possible by the development of a standardized preparation of the drug (intocostrin—Squibb). Each cubic centimeter of intocostrin contains 20 mg. of curare. This solution is relatively stable and may be kept at room temperature for a limited time. Storage for longer periods of time requires refrigeration.

The use of curare in clinical anesthesia was first reported by Griffith[6] in 1942. He reported that when adequate muscular relaxation could not be obtained with inhalation anesthesia, 100 mg. of curare injected intravenously would promptly cause complete abdominal relaxation for a short period of time. In Griffith's experience, the only undesirable complication was a limited period of respiratory depression. Adequate pulmonary ventilation was readily maintained during this period by exerting intermittent pressure on the breathing bag of the gas machine. Griffith's[7] subsequent experience with curare as a means of increasing muscular relaxation during inhalation anesthesia has continued to be satisfactory.

Cullen[8,9] has also reported clinical and experimental evidence that this drug may be safely used in anesthesia to improve relaxation. He has noted that the abdominal muscles are paralyzed before the muscles of respiration. The principal disadvantage of curare in Cullen's experience is the narrow margin between abdominal relaxation and respiratory depression. We have likewise observed that the amount of curare required to produce complete abdominal relaxation often causes inefficient respiratory activity or complete respiratory arrest.

When we started the use of curare, the patient was first anesthetized with cyclopropane and an effort was made to produce abdominal relaxation without loss of normal respiratory activity. Adequate pulmonary ventilation was maintained by varying the depth of the inhalation anesthesia. With this technic it was difficult to prevent respiratory depression, and manual inflation of the lungs was occasionally required. This method was satisfactory in some cases, but too often the relaxation would be uneven when a good respiratory exchange was maintained. When enough curare was used to produce good relaxation, then the respirations were often inadequate because there is very little difference in the amounts of curare required to cause abdominal relaxation and respiratory depression.

If the inhalation anesthesia became too light, muscular spasms and twitching would sometimes occur. Spasms of the muscles of respiration and bronchospasm were serious complications and often resulted in marked circulatory depression. Better results were obtained when sufficient cyclopropane was given to prevent reflex stimulation. The occurrence of muscular spasms was considered an indication for more curare and cyclopropane. The initial dose of curare varied from 10 to 180 mg. In the average case 20 to 40 mg. were given and repeated at five-minute intervals until the desired relaxation was obtained. Whenever the pulmonary ventilation was inadequate, artificial respiration by intermittent bag pressure was instituted. This combination of cyclopropane and curare was well tolerated even by poor risk patients.

Curare and cyclopropane or cyclopropane and ether was used in Cesarean sections with satisfactory results. As much as 150 mg. of curare was given intravenously without any apparent depressing effect on the baby. The average amount used in these cases was 100 mg. given either in single or divided doses. In all cases the babies cried spontaneously or were only slightly

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depressed. The respiratory depression that did occur seemed to depend on the amount of inhalation anesthesia used. The use of curare has decreased the amount of inhalation anesthesia ordinarily required for Cesarean sections, thus decreasing the incidence of severe respiratory depression of the baby. However, the depression is still somewhat greater than with local or spinal anesthesia.

When ether anesthesia is used, 20 mg. of curare will improve the degree of abdominal relaxation. It is often necessary to repeat this dose several times before complete relaxation is obtained and additional doses of curare may be required throughout the operation to maintain relaxation. Following the injection of curare, respiratory activity may be depressed for a short period of time. It is essential to maintain good pulmonary ventilation by artificial respiration during this period of respiratory depression.

The use of curare decreases the amount of ether required and the patients react more promptly following the operation. Small doses of curare with ether were satisfactory although circulatory depression occurred more frequently than with cyclopropane. When larger doses, 100 mg. or more, are given during ether anesthesia, serious circulatory depression may occur. In one patient anesthetized with ether, 100 mg. of curare precipitated immediate circulatory and respiratory failure, which required active treatment. Such reactions have not been observed with cyclopropane. This agrees with Cullen's observation that small doses of curare should be used with ether anesthesia.

Curare has been used in conjunction with combined spinal and cyclopropane anesthesia when the relaxation was incomplete. In this situation, curare in 100 mg. doses produced prompt and complete abdominal relaxation, without causing circulatory depression. In cases where the effect of the spinal anesthesia wore off before the operation was completed, smaller doses were often sufficient.

Curare was used alone or with local anesthesia in a few cases. Its use in this manner was effective in improving the relaxation for intra-abdominal operations in babies. In these cases a tight fitting oral tracheal tube was first inserted. This was connected with a supply of oxygen which could be delivered under controlled pressure. In some cases the relaxation is satisfactory without curare, but when more relaxation is required an initial intramuscular injection of 0.5 mg. per kilogram of body weight is given and then repeated as necessary. One injection is often all that is required.

Several abdominal operations were performed on adults using only curare. One patient had a Cesarean section and had lost considerable blood due to a placenta praevia. Blood and plasma transfusions were started before the operation. The administration of 60 mg. of curare caused some depression of respiration and considerable twitching and muscular spasms of the upper part of the body. An additional 40 mg. four minutes later caused loss of consciousness and respiratory paralysis. Artificial respiration was instituted and the circulation improved, as indicated by an increase of blood pressure and a decrease of the pulse rate. The patient regained consciousness 20 minutes later as the operation was being completed. Respiratory activity had started to return 10 minutes before the patient became conscious.

Another patient had a resection of the colon lasting 2 hours and 15 minutes. An initial dose of 125 mg. of curare caused immediate loss of consciousness and respiratory arrest. Additional doses of 20 to 40 mg. were given during the operation whenever there was evidence of bronchospasm. This was indicated by an increased resistance to artificial inflation of the lungs. In this patient 405 mg. of curare were required to maintain a state of complete relaxation and unconsciousness throughout the course of the operation. The circulation was well maintained at all times. Respiratory effort started as the operation was being completed and consciousness returned 45 minutes later. However, adequate respiratory exchange did not return until four hours after the operation was completed. The respiratory depression may have beeen unduly prolonged by the adminstration of morphine during the recovery period.

This sequence is similar to that observed in dogs. When large doses of curare are given, the time required to recover from the stage of complete muscular relaxation may require several hours. This is a serious objection to the use of curare alone for surgical operations. Various drugs [10,11] have been recommended to counteract the effects of curare, but as yet their value with large doses of curare has not been established.

DISCUSSION

The effect of curare may be divided into two stages: first, the stage of incomplete relaxation of the skeletal muscles; and second, the stage of complete relaxation of the skeletal muscles. In the lower part of the first stage there is a zone in which muscular spasms or twitching may occur. Muscular spasms occur more frequently with large doses of curare particularly when the accompanying general anesthesia is inadequate. West[12] has reported the occurrence of spasms of the muscles or respiration when curare was used. This muscular hyperactivity may be a serious complication when it interferes with pulmonary ventilation. Another undesirable effect of large doses of curare is the accumulation of thick tenaceous mucous in the mouth and throat. Atropine

and scopolamine are of value, but they do not entirely prevent this hypersecretion of mucous.

Curare was used without general anesthesia in a few surgical cases. After the administration of sufficient drug to cause complete muscular paralysis loss of consciousness occurred. Fegler[13] has previously demonstrated a direct central effect of curare. When curare is used in this manner, there may be a postoperative period of respiratory depression. This causes considerable inconvenience because artificial respiration must be maintained until the effect of curare has worn off. If there is danger of regurgitation of stomach contents during the operation, an endotracheal tube should be employed. This is necessary to prevent aspiration since the muscles of the pharynx and larynx are paralyzed by large doses of curare.

SUMMARY

The use of curare to improve muscular relaxation during anesthesia has been sufficiently satisfactory in our experience to warrant further trial. It is possible to produce partial or complete paralysis of the skeletal muscles, depending on the amount of drug given. In most instances we have found it preferable to use curare as a supplement to general anesthesia in reasonable doses.

When large doses of curare were used, several complications were observed. Thick tenacious mucous would accumulate in the mouth and throat and interfere with the respiratory exchange. Muscular spasms and twitchings often resulted, unless adequate general anesthesia was maintained until the principal effect of the curare was eliminated. During the operation these muscular spasms may cause serious circulatory depression when they interfere with pulmonary ventilation. This complication may be avoided by maintaining a proper depth of anesthesia or by giving sufficient curare to cause complete muscular relaxation. Another disadvantage of large doses is the prolonged period of inadequate respiratory exchange, during which time it is necessary to employ artificial respiration. Since the muscles of the pharynx and larynx are also paralyzed, there is an increased danger of aspiration of regurgitated stomach contents.

In our experience curare and cyclopropane, or curare, cyclopropane and ether have been satisfactory combinations. When ether was used there was a greater incidence of circulatory depression unless the administration of curare was very carefully controlled. Curare has also been a useful supplement to spinal and cyclopropane anesthesia. Curare alone or with local anesthesia has been used, but as yet it does not seem to be practical except in selected cases. Curare seems to be well tolerated even by poor risk patients and permits the use of smaller quantities of other agents. However, more experience is required before its scope of usefulness in anesthesia can be determined.

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Correction in Paper by Dr. Ivy

In the article, "Functional and Organic Diseases of the Gastrointestinal Tract: Physiological and Medical Considerations", by Dr. A. C. Ivy, Chicago, published in the October, 1944, issue of *The Journal*, there appeared a numerical error, first column, page 927.

The first sentence of the second paragraph in the column referred to should have read:

"If the stomach were examined every three months it is probable that death from cancer of the stomach could be reduced by about 30 per cent." The figure "90" per cent was used erroneously in the original.

In requesting the correction of this figure, Dr. Ivy stated:

"I might add that the figure of 30 per cent is based on the well authenticated fact (Livingston and Pack, "End Results in the Treatment of Cancer of the Stomach", 1939) that autopsies reveal that in approximately 25 per cent of persons dying of cancer of the stomach the lesion is still confined to the stomach and immediately adjacent lymph nodes and hence is resectable. I added 5 per cent to the figure, because it is reasonable to assume that early diagnosis will increase the per cent of curable resectable cancer sufficiently to more than cover the operative mortality which is now only 8 per cent in some instances".

Strangulated Diaphragmatic Hernia and Serosanguineous Pleural Effusion*

CARL J. PFAHL, M.D., and HERBERT Z. LUND, M.D.

Present Illness. J.G., a 29 year old negro, was admitted to Cleveland Hospital on March 5, 1944, complaining of pain in the chest and vomiting. Two days before, while at work shoveling coal, he was seized with a severe cramplike pain extending along the left lateral aspect of the chest and into the left upper abdominal quadrant. The pain became rapidly more severe and within an hour he began to vomit. These symptoms were persistent. The vomitus became "coffee-ground" in appearance.

Past History. Eighteen months before the present illness the patient was stabbed in the left side of the chest and developed a pneumothorax. This was demonstrated by fluoroscopic examination. After 2 weeks of bed rest the pneumothorax was no longer demonstrable and he was symptom-free, remaining so until the present illness.

Physical Examination revealed a well developed, well nourished negro appearing acutely ill, cyanotic, weak and drowsy. The skin was cold and clammy. Temperature was 38.7° C., the pulse 120 per minute, respirations 48 per minute, and the blood pressure was 58/40. The pulse was rapid and thready; respirations were labored. The trachea was displaced to the right. In the lower part of the left hemothorax anteriorly and laterally there were diminished breath sounds, absent tactile fremitus and flatness to percussion. The heart and mediastinum were displaced to the right. There was a small linear cutaneous scar in the eighth intercostal space in the left posterior axillary line. The abdomen was flat. No masses were palpable. There was tenderness with voluntary rigidity in the left upper quadrant. Borborygmi were heard.

Laboratory Examination. The urine was not remarkable. The erythrocyte count was 5,000,000 per cu. mm., the hemoglobin was 80 per cent (14 Gm. per 100 cc.) and the leucocyte count was 29,000 per cu. mm. Radiographs of the thorax were made upon admission; these showed fluid in the left pleural cavity with displacement of the heart and mediastinum to the right, and what was interpreted as elevation of the left leaf of the diaphragm. Culture of pleural fluid failed to show organisms.

Hospital Course. Upon admission saline and plasma were given intravenously. One thousand cc. of bloody fluid was aspirated from the thorax. Following this the blood pressure rose to 128/80 and the respiratory embarrassment partially subsided. Upon starting Wangensteen drainage large quantities of "coffee-ground" fluid returned. This showed a strongly positive benzidine reaction. The patient remained weak, disoriented and irrational. The blood pressure rapidly declined and he died 15 hours after admission.

The clinical diagnoses were: Spontaneous hemothorax; shock due to blood loss; probable intestinal obstruction; and probable peptic ulcer.

AUTOPSY

Externally the only change of note was a scar 1 cm. long in the eighth intercostal space in the left posterior axillary line, its long axis parallel to the ribs. Section disclosed a diaphragmatic hernia. The opening in the diaphragm was approximately 1.5 cm. in diameter and was situated in the left leaf laterally in a plane corresponding to the midaxilla. The margins of the opening were firm and inelastic. Through this opening was a loop of colon 15 cm. in length consisting or part of the transverse and splenic flexures. Included with it were mesocolon and omentum. There was no hernial sac. The intestine within the pleural cavity was purple, markedly distended and hemorrhagic. Its mucosa was grayish red. The adjacent mesocolon was thick and hemorrhagic, and its veins were distended with blood.

These changes terminated sharply at the diaphragmatic opening. Here the loop of colon was markedly constricted. Proximal to the opening the colon was moderately distended; distally it was empty and contracted. The small intestine was moderately distended. That portion of the colon in and just above the hernial ring was bound by fibrous adhesions which originated from the pleural surface of the diaphragm and were reflected over and attached to the serosa of the colon for approximately 2 cm. There were scattered fibrous adhesions extending from the parietal pleura to the left lung. The left pleural cavity contained 2,300 cc. of deep red, opaque fluid having a specific gravity of 1.030. The left lung was diminished in volume occupying approximately the upper and medial half of the pleural cavity. The lower and lateral parts of the cavity were occupied by the hernia and the fluid.

Microscopic examination of the colon within the thoracic hernia showed necrosis of all coats, marked hyperemia, distention of veins and capillaries, and extensive interstitial hemorrhage. There was an exudation of polymorphonuclear cells within the muscularis and subserosa. The margins of the opening in the diaphragm showed fibrosis.

The principal anatomical diagnoses were: Diaphragmatic hernia (probably traumatic in origin) of transverse colon into the left thoracic cavity with strangulation; serosanguineous pleural effusion (2,300 cc.); hemorrhagic bronchopneumonia; remote stab wound of thorax.

DISCUSSION

Diaphragmatic hernia is defined as a protrusion of abdominal contents through an anatomically weak area or through an abnormal opening in the diaphragm the result of imperfect development, anatomical weakness or trauma (Hed-

*Selected by H. T. Karsner, M.D., from the Clinical-Pathological Conferences at Cleveland City Hospital, Cleveland, Ohio, as the twenty-fourth of a series of "Case Records Presenting Clinical Problems".

blom[1]). Traumatic hernias may result from direct or penetrating injury, or from an indirect or nonpenetrating injury.

Examples of the former are stab wounds, gunshot wounds, or puncture by the sharp end of a fractured rib. Examples of indirect injury are tearing or bursting of the diaphragm from sudden violent abdominal or thoracic compression as from a fall, blow or crushing impact. Traumatic diaphragmatic hernias comprise about 38 per cent of all types. Nearly 95 per cent of these are on the left side; approximately one-half are lateral and one-fourth central.

Over 90 per cent of traumatic hernias occur in males; this seems to be due to the greater incidence of severe injury to males. Approximately 52 per cent of traumatic hernias are due to penetrating injuries and 48 per cent to blunt violence. About 70 per cent of penetrating injuries are due to stab wounds (see Hedblom[1]).

A sac is a component part of a true hernia but the great majority of those of traumatic origin have no sac and are designated as "false hernias". In those few cases of traumatic hernia which have a sac there has been evidence of incomplete tear or stab leaving the pleura or peritoneum intact.

In the case presented, the fact that the diaphragmatic defect corresponded in location with the scar of the chest wall confirms the assumption that the hernia resulted from the stab received 18 months previously. Incisions of the diaphragm of this nature seldom heal without a defect for the transversely cut fibers retract and are held apart by protruding abdominal viscera. Only those incisions of the diaphragm running parallel to the direction of the muscle fibers heal spontaneously (Repetto[2]). Although a protrusion of abdominal contents occurs immediately after the injury due to the difference in the abdominal and thoracic pressures, symptoms of the hernia do not occur for several months as a rule (Bryan[3]).

In the case presented the question was raised as to whether or not the colon was herniated immediately after the injury. It was argued that a herniation of the colon through a 1.5 cm. opening would have caused symptoms of obstruction much earlier than was the case. However, the autopsy showed that the loop of colon had been within the pleural cavity for a long period of time for there were fibrous adhesions from the colon to the pleura. That the hernial protrusion may have been enlarged by the vigorous muscular effort at the onset of the acute symptoms can not be affirmed or denied. The hernial ring at the time of the autopsy was rigid due to the presence of fibrous tissue. Fibrosis is a progressive process and therefore it would seem logical to assume that with time a traumatic hernia becomes more and more liable to constriction and strangulation due to the increasing rigidity and stenosis of the hernial orifice.

Deaner, McMenemey and Smith[4] report a case of hemothorax due to strangulated diaphragmatic hernia. In their case a large mass of clotted blood was found within the thorax, the exact volume of which was not stated. They claim this case is without parallel in the literature. They speak of other reports of blood in the pleural cavity "but only as a fortuitous finding". Whether the case presented is to be considered one of hemothorax depends largely on definition of the term. The fluid was deep red, indistinguishable from free blood, but the specific gravity was 1.030, less than that of normal blood. It was unclotted and did not clot after removal. It is perhaps preferable to speak of this as a serosanguineous effusion. Be that as it may, the loss of blood within the thorax was massive for a total of 3,300 cc. of fluid was removed and the loss was undoubtedly an important factor in the death of the patient. If the "coffee ground" character of the vomitus and fluid drained by the Wangensteen tube was actually due to the presence of blood, there was no lesion of the stomach to explain it.

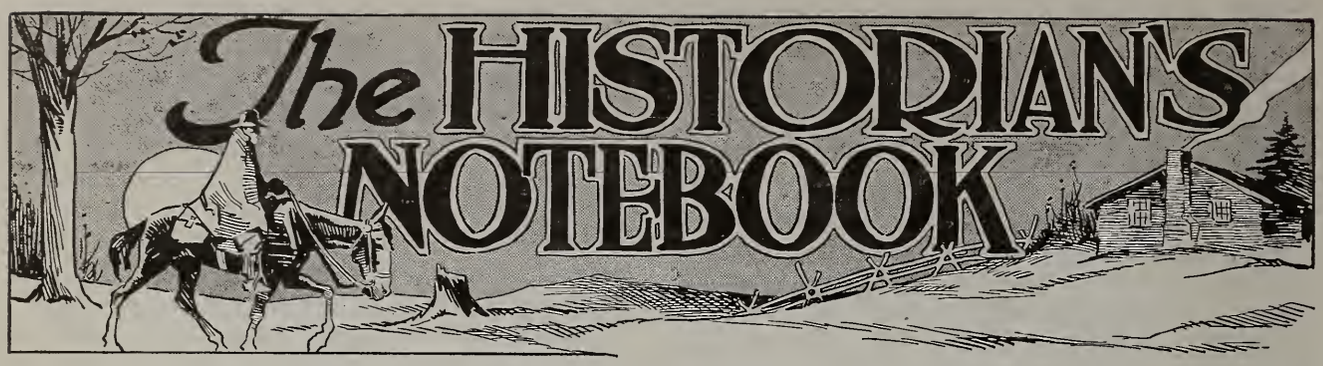
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Disorders of the Intestine

The roentgenogram plays an important role in the diagnosis of intestinal disorders. With the exception of patients suspected of having low-bowel obstruction, a barium meal with films taken at suitable intervals to show the small intestine and cecum, followed in twenty-four hours by a barium enema, yields the most conclusive findings. The small bowel is best studied by films taken at hourly intervals for a period of six hours after a barium meal. The serial films reveal small-intestinal motility, obstruction, dilatation, and changes in the caliber, flexibility, and mucosal pattern.

Certain limitations of roentgenologic diagnosis must be kept in mind. Since narrowing of the lumen of the small bowel may cause no delay until obstruction is almost complete, intermittent small-intestinal obstruction, particularly when caused by bands of adhesions, may not be evident roentgenologically unless the examination is made in the presence of symptoms of obstruction. Everett D. Kiefer, M.D., Boston; N. Y. State Med. Jr., Vol. 44, No. 21, Nov. 1, 1944.



Kept by David A. Tucker, Jr., Cincinnati, Ohio

Pioneering in Physical Education

PHILIP D. JORDAN, PH.D., Oxford, Ohio

ORGANIZED, formal exercise designed to develop muscle and to promote health became increasingly popular in the United States after the Civil War. Schoolmen and physicians acclaimed calisthenics as a preventative of disease and as a postive boon to the body beautiful. "The true educator," wrote a teacher, "sees in the present public interest in Physical Education a promise and a hope."

By 1863 gymnastics were being experimented with in the public schools of Ohio. At that time Lyman Harding, superintendent of schools in Cincinnati, went on record to the effect that calisthenics had proved a decided success. In Cleveland, the Ohio State Teachers' Association, meeting in July, resolved that gymnastic training should be introduced into all the schools of the state and made as indispensable in the daily routine of duties as the other exercises of the classroom. "To those who have seen the wan cheeks, stooping shoulders, and sunken chests of the school-children of today," said James H. Smart, a teacher in the Toledo High School, "no argument, proving the necessity of physical culture, need be made."[1]

Physicians and school commissioners, in general, took this same gloomy outlook, but they seemed in no hurry to endorse a general program to fit the pupil for health. John A. Norris, commissioner of common schools, said in 1866: "In our haste to perfect a system of popular education, we have neglected the part that looks to physical training and that muscular development so necessary to a healthy body."[2] He, prompted by memories of the recent War Between the States, urged that the school of the soldier be taught children.

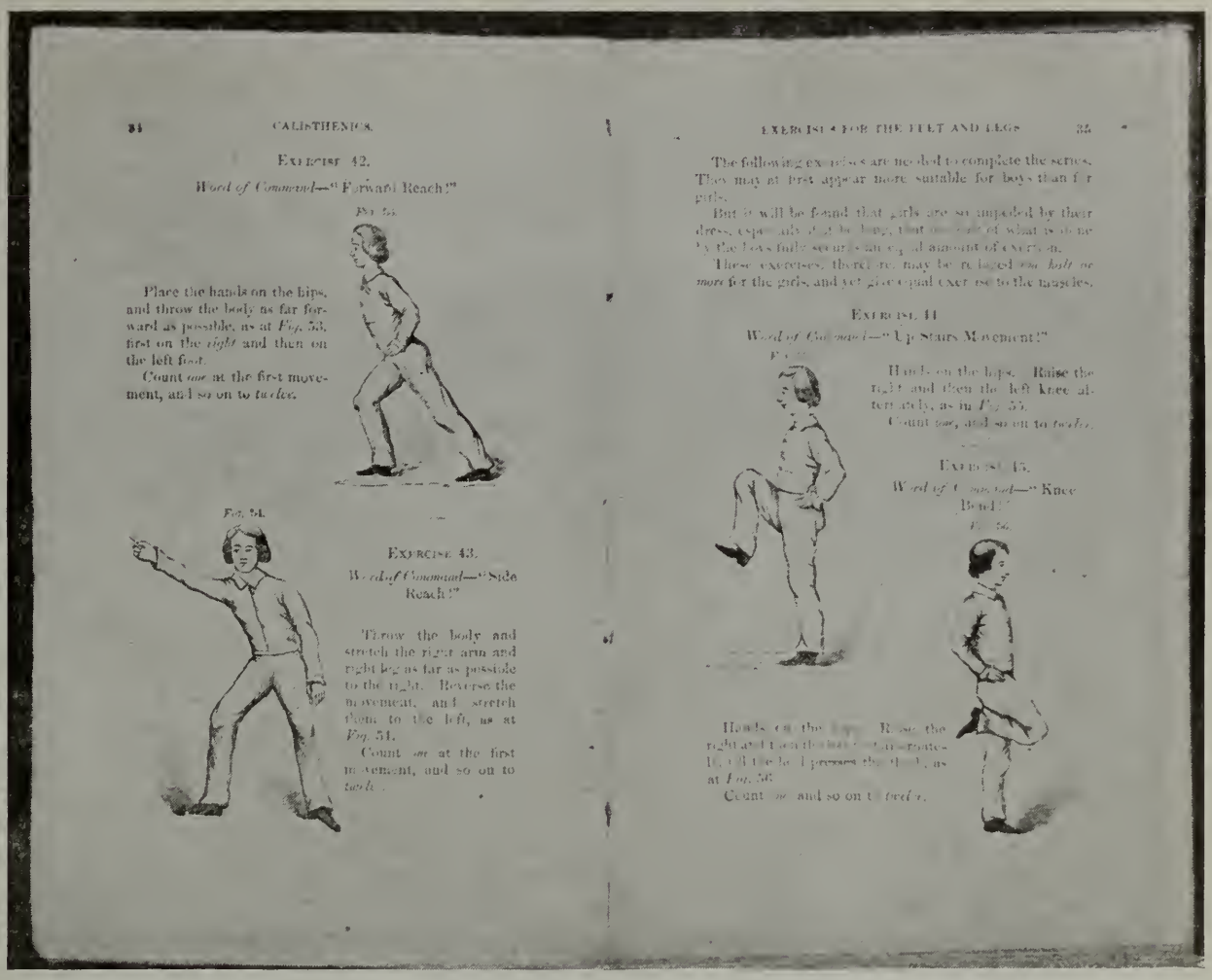
There were several social factors operating in Ohio and throughout the nation which seemed to make imperative physical culture. During the formative years of the country Americans developed their bodies informally. Forest trees were to be cut. Cabins were to be hewn from rough logs. Stones were to be lugged from Ohio's many streams for use in fireplaces and chimneys. The hunter tracking the deer and the trapper following his lines got regular exercise. Children helped with vigorous household chores—washing, carrying water, bringing in wood, and turning the spit. They swam in the creeks, climbed the hickory trees, and slid down icy winter hills. Everyday chores and everyday play provided exercise for every member of a pioneer family.

But the pattern of life in Ohio had changed by the middle of the nineteenth century. No longer was the state a frontier community. The great trees had disappeared. Even agriculture was being superseded by industry and commerce. More and more people were being forced into the matrix of confined urban areas. Fewer and fewer Buckeyes could gain their exercise as a part of their daily occupations. Informal muscle training had to give way to formalism. Gymnasiums replaced the simpler places where the frontiersmen had found their exercise.

Ohio physicians were quick to recognize the worth of gymnastic instruction in calisthenics and many urged the use of two manuals popular during the fifties and sixties. Catharine E. Beecher published in 1856 her *Physiology and*

The Author

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34 CALISTHENICS.

EXERCISE 42.

Word of Command—"Forward Reach!"

Fig. 53.

Place the hands on the hips, and throw the body as far forward as possible, as at *Fig.* 53, first on the *right* and then on the left *foot*.

Count *one* at the first movement, and so on to *twelve*.

Fig. 54.

EXERCISE 43.

Word of Command—"Side Reach!"

Throw the body and stretch the right arm and right leg as far as possible to the right. Reverse the movement, and stretch them to the left, as at *Fig.* 54.

Count *one* at the first movement, and so on to *twelve*.

EXERCISES FOR THE FEET AND LEGS. 35

The following exercises are needed to complete the series. They may at first appear more suitable for boys than for girls.

But it will be found that girls are so impeded by their dress, especially that long, that [illegible] of what is done by the boys fully secures an equal amount of exercise.

These exercises, therefore, may be regarded *as half as more* for the girls, and yet give equal exercise to the muscles.

EXERCISE 44.

Word of Command—"Up Stairs Movement!"

Fig. [illegible]

Hands on the hips. Raise the right and then the left knee alternately, as in *Fig.* 55.

Count *one*, and so on to *twelve*.

EXERCISE 45.

Word of Command—"Knee Bend!"

Fig. 56.

Hands on the hips. Raise the right and [illegible] as at *Fig.* 56.

Count *one* and so on to *twelve*.

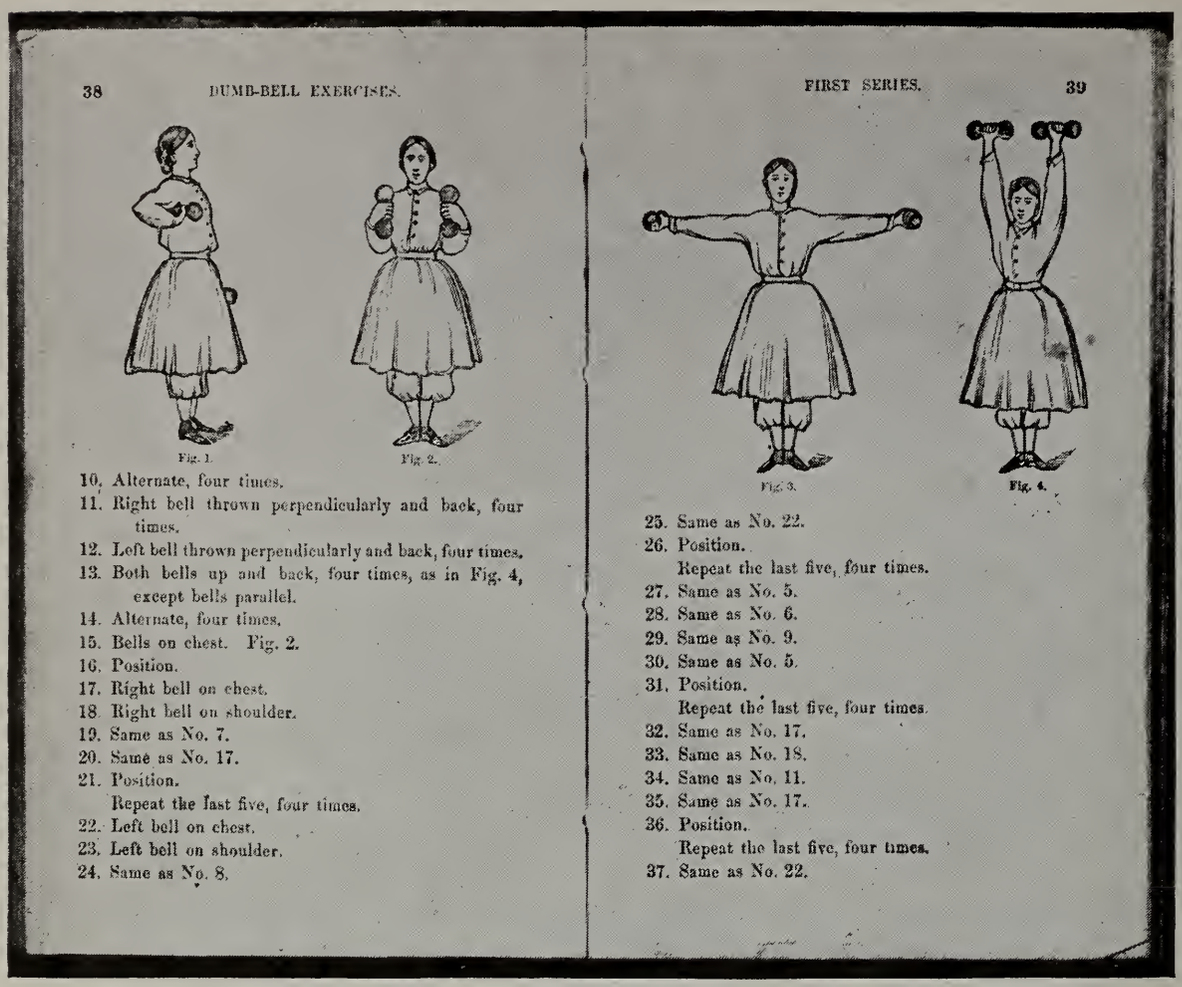
Exercises for Feet and Legs. (From: Catharine E. Beecher, "Calisthenic Exercises", p. 34-5.)

Calisthentics designed to give the laity a "short, easy, and comprehensive" course in physiology and hygiene.[3] This included calisthenics which Miss Beecher maintained could be practiced in "schools of every description, in the family, in nurseries, in hospitals, and in health establishments, *without apparatus*, and *without a room set apart for the purpose.*"[4] Waxing enthusiastic, as did all the Beechers when they became interested in an activity, Miss Beecher continued: "The member of a family in the parlor, the children in the nursery, the invalid in the chamber, the seamstress and milliner in their shops, the student or professional man in his office, study, or counting-room, can open a window twice or thrice a day and have all the 'fresh air and exercise' needed for *perfect health*, by simply following the directions in this work."[5]

Although general directions were mentioned in her first little volume, specific instructions, complete with illustrations were not presented until the appearance of her second volume. This also was published in 1856[6] and by the end of the year the two were bound within a single volume. Professional and popular opinion soon was so enthusiastic that the one-volume edition quickly became exhausted. It is perhaps true that physicians belonging to the regular schools did not endorse Miss Beecher's system as completely as did men on the medical fringe—the followers of hydrotherapy and of Thomson's botanic system.

This reluctance on the part of the better educated doctors stemmed, in part, from the elaborate claims which Miss Beecher set forth. "The author," wrote Miss Beecher, speaking apparently from her own knowledge, "has known cures performed in health establishments and elsewhere, by means of these exercises, in connection with a strict enforcement of the laws of health, very much greater than anything she has ever known effected by *any* method of medical treatment. Headaches, dyspepsia, all varieties of nervous diseases, lung and liver complaints, local diseases and weakness, and a great variety of deformities, have been remedied by this method."[7]

Smart, writing from his classroom experience in Toledo, did not make quite such comprehensive claims, although he maintained that systematic exercise tended to develop muscles, to remove the tendency to consumption, and to invigorate the whole system.[8] But if Beecher and Smart differed in the extent of their claims, they were almost perfectly agreed on technique and method. Of course, both were stimulated by nineteenth century developments in physical culture which



38 DUMB-BELL EXERCISES.

Fig. 1. Fig. 2.

10. Alternate, four times.
11. Right bell thrown perpendicularly and back, four times.
12. Left bell thrown perpendicularly and back, four times.
13. Both bells up and back, four times, as in Fig. 4, except bells parallel.
14. Alternate, four times.
15. Bells on chest. Fig. 2.
16. Position.
17. Right bell on chest.
18. Right bell on shoulder.
19. Same as No. 7.
20. Same as No. 17.
21. Position.
Repeat the last five, four times.
22. Left bell on chest.
23. Left bell on shoulder.
24. Same as No. 8.

FIRST SERIES. 39

Fig. 3. Fig. 4.

25. Same as No. 22.
26. Position.
Repeat the last five, four times.
27. Same as No. 5.
28. Same as No. 6.
29. Same as No. 9.
30. Same as No. 5.
31. Position.
Repeat the last five, four times.
32. Same as No. 17.
33. Same as No. 18.
34. Same as No. 11.
35. Same as No. 17.
36. Position.
Repeat the last five, four times.
37. Same as No. 22.

Exercises for Chest and Arms: (From: James H. Smart, "Manual of Free Gymnastic and Dumb-Bell Exercises", p. 38-9.)

were taking place in Sweden and Germany. Each of these foreign disciplines was highly formalized.

Early calisthenics in Ohio called for loose clothing suspended, as far as possible, from the shoulders. The exercise was to be taken in a room filled with fresh air. When possible, music of an appropriate nature was to be played. Smart, for example, said that some "soul-stirring" music would be effective in removing idleness and mischievousness, and in "clearing away clouds that often settle upon pupils and teacher."[9] Among the tunes suggested were the "Red, White, and Blue"; "Yankee Doodle"; "Hail, Columbia"; "Happy Meet We Here"; and "All Hail the Joyful Morning."

Preliminary exercises concerned the development of the chest and lungs and, in the main, were devoted to proper breathing. Then came drills to improve the muscles of the arms and hands which were followed by exercises for strengthening the muscles of the trunk. These included the well-known "side-swing," "side neck movement," and "side twist." Drills for the feet and legs were designed to give strength, elasticity, and correct movement to those parts.

More advanced training included the use of weights, shaped somewhat like a brick, by Miss Beecher, and the use of the dumb-bell by Smart. The dumb-bell, according to Smart, should be made from wood and should be at least three and a half inches in diameter. In weight, they were to range from one to three and a half pounds.[10] Dumb-bell exercises primarily were used to further develop arms, hands, and shoulder and chest muscles.

Not all health advocates, however, endorsed formal calisthenics as recommended by Beecher and Smart. As early as 1844 it was said that the diversions which afford the best exercise were hunting, shooting, playing at cricket and at handball, because such activities improve the "limbs, promote perspiration, and the other secretions."[11] Buchanan also cautioned against over-exertion, for he said that fatigue prevents the benefit of exercise, and instead of developing the body tends to weaken it. He also recommended that no one type of activity be engaged in and said that the dumb-bell, dancing, and fencing should be used in turn. However, he continued, "those kinds of exercise which give action to most of the bodily organs, are always to be preferred, as walking, running, riding, digging, rubbing furniture, and the like."[12]

Even Dr. W. W. Hall, whose health pamphlets sold in such astonishing numbers during the sixties and who was considered by many of his professional brethren a fakir, raised his voice

against the over-formalization of physical training. Although Hall approved of exercise, saying that it is health-producing because "it works off and out of the system its waste, dead, and effete matters,"[13] he cautioned against training in artificial ways. Speaking of proper posture, he maintained that "Instead of giving all sorts of rules about turning out the toes, and straightening up the body, and holding the shoulders back, all of which are impracticable to many, because soon forgotten, or of a feeling of awkwardness and discomfort which procures a willing omission; all that is necessary, to secure the object, is to *hold up the head and move on!* letting the toes and shoulders take care of themselves."[14]

Despite the controversy developing between the formalists and those devoted to a more informal method of physical instruction, education for physical fitness in Ohio moved steadily forward until today the best in each school has been recognized and incorporated. But modern training is possible only because of the early pioneer work of such individuals as Beecher and Smart.

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4. Ibid., iv.
5. Ibid., v.
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7. Ibid., iii.
8. Smart, op. cit., iv.
9. Ibid., iv.
10. Ibid., 35.
11. William Buchanan, Family Medical Library: A Treatise on the Prevention and Cure of Diseases (Cincinnati, 1844), 60.
12. Ibid., 59-60.
13. Hall's Journal of Health (New York), XII (1865), Tract 174, "Philosophy of Exercise."
14. Ibid., Tract 11, "An Erect Position Adverse to Consumption."

Chicago Medical Society Announces Second Clinical Conference

The Chicago Medical Society will hold its Second Annual Clinical Conference at the Palmer House, Chicago, on February 27, 28 and March 1, 1945. The program presented at the first conference, last Spring, was enthusiastically received by the several thousand physicians who attended. The committee is already under way in securing speakers on important subjects for the 1945 conference. Exhibits, both technical and scientific, will be greatly increased. Early reservations at the Palmer House, Chicago, are recommended.

New York Meeting of A.M.A. Off; Another City To Be Picked

BECAUSE of conditions brought about by the war the necessary facilities will not be available in New York City for the 1945 annual session of the American Medical Association, scheduled for June 11 to 15, and thus it will have to be held in some other city where adequate facilities will be available, it is reported in the November 11 issue of *The Journal* of the Association. The announcement says:

"The House of Delegates of the American Medical Association at the annual session held in 1942 selected New York City as the place of meeting for the 1945 annual session. Certain preliminary arrangements were completed, but investigations recently made in New York clearly indicate that the necessary facilities will not be available in that city in 1945 because of conditions created by the war emergency. It is with regret that it is necessary to make the announcement that the annual session scheduled for New York, June 11 to 15, 1945, will have to be held in some other city where adequate facilities will be available. Under the direction of the Board of Trustees necessary investigations are now in progress and definite announcement as to the place of meeting for 1945 will be made through the columns of *The Journal* at the earliest possible time."

$34,000 In War Bonds As Prizes

War bond prizes totaling $34,000 will be awarded for the best art works by physicians, memorializing the medical profession's "Courage and Devotion Beyond the Call of Duty" (in war and in peace).

This prize contest is open to any physician-member of the American Physicians Art Association, including medical officers in the armed forces of the United States and Canada.

Full information is available on request of the sponsor, Mead Johnson & Co., Evansville, Ind., U.S.A.

Coming Meetings

Ohio State Medical Association, Columbus, May 1-3, 1945.

American Society of Anesthetists, New York, Dec. 14.

Southern Surgical Association, Hot Springs, Va., Dec. 5-7.

Western Surgical Association, Chicago, Dec. 1-2.

Proceedings of The Council

Organization of Stock Company to Write Medical Coverage on Cash Indemnity Basis Approved on November 12; Budget for 1945 Adopted; Miscellaneous Business

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the State Headquarters Office, Columbus, on Sunday, November 12, 1944. Those attending were: President Schriver, President-Elect McNamee, Past-President Sherburne, Treasurer LeFever; Councilors Swartz, Messenger, Noble, Brindley, Dixon, Rutledge, Lincke, Swan, Micklethwaite, Harding, and Knoble; Dr. Forman, Editor of *The Journal*; the following members of the Committee on Medical Service Plans: Dr. Rothenberg, Dr. Young, Dr. Mundy, Dr. Ames, Mr. Cooley; Mr. Wayne Stichter, Toledo, legal counsel; Executive Secretary Nelson and Assistant Executive Secretary Saville.

On **motion** by Dr. Knoble, seconded by Dr. Micklethwaite, and **carried**, the minutes of the last meetings of The Council held on September 9 and 10, 1944, were **approved**.

The Executive Secretary reported the total membership of the Association as of November 11, 1944, was 6,825, of which 1,932 were military members; compared to a total membership of 6,780 on December 31, 1943, of which 1,771 were military members.

President Schriver and Past-President Sherburne reported on the four-state conference held in Cincinnati on October 29, under the auspices of The Council on Medical Service and Public Relations of the American Medical Association. Both stated that in their opinion the meeting was extremely beneficial to all in attendance and they expressed the hope that similar meetings would be held as frequently as possible.

SPECIAL APPOINTMENTS

President Schriver appointed Dr. E. J. Wenaas, Youngstown, as a member of the Judicial and Professional Relations Committee for a term ending in 1946 to succeed Dr. J. G. Kramer, Akron, recently appointed to the Committee on Public Relations and Economics to fill a vacancy on that committee. On **motion** by Dr. Dixon, seconded by Dr. Swartz, and **carried**, this appointment was confirmed by The Council.

President Schriver re-appointed Dr. Jonathan Forman as representative of the Ohio State Medical Association on the Ohio Nutrition Committee, War Food Administration. On **motion** by Dr. Sherburne, seconded by Dr. Swan, and **carried**, this appointment was confirmed by The Council.

President Schriver informed The Council that it would be necessary for The Council to appoint a chairman and a secretary for the Section on Public Health and Preventive Medicine, the former officers of that section having left the state. On **motion** by Dr. Sherburne, seconded by Dr. Micklethwaite, and **carried**, the President was authorized to appoint suitable officers for this section.

STREAM POLLUTION

In a statement to The Council, President Schriver pointed out that he felt medical organization should be more affirmative and more vocal on matters of public health and that it should take an active, constructive part in the promotion of programs found to be beneficial to the health and welfare of the public at large. He pointed out particularly the desirability for the medical profession to take an active part in programs for the elimination of stream pollution, especially in the Ohio River Valley. Dr. Schriver stated that he felt the physicians of the Ohio River Valley states, with a population of approximately 35,000,000 people, should lend their active support to pending Federal legislation on this question and that the individual state medical societies should lend their support to enabling legislation which would make it possible for the individual states to participate in stream pollution projects. On **motion** by Dr. Micklethwaite, seconded by Dr. Messenger, and **carried**, President Schriver was authorized to select a committee to draft suitable resolutions on stream pollution. One set of resolutions would be sent to the medical societies of the States of Pennsylvania and Virginia, urging them to use their influence with their state legislatures and to bring those states into the Ohio River Valley states compact so that there would be a united front in promotion of legislation on this matter. Another set of resolutions would be prepared for submission to members of the Congress, before which stream pollution legislation is pending.

MEDICAL INDEMNITY PLAN APPROVED

At this point President Schriver introduced the members of the Committee on Medical Service Plans and asked Dr. Rothenberg, the chairman of that committee, to submit to The Council a special report from that committee.

Dr. Rothenberg reviewed the activities of the committee during the past several months. He pointed out that it was the belief of the committee that it would not be feasible at this time to attempt to establish a medical service plan, or several medical service plans, in Ohio under the provisions of the Enabling Act because of the income ceiling established in the Enabling Act and because of underlying difficulties in

A Special Message to the Membership . . .

DURING the ensuing month, most of the County Medical Societies in Ohio will hold their annual meetings for the election of officers for 1945.

We appeal to each member of the Ohio State Medical Association, not only to make a special effort to attend the annual meeting of his County Medical Society, but to exercise wisdom and discretion in the matter of selecting those who will occupy official positions in the society during the next year.

The need for strong and active medical societies was never more apparent than today. Vital issues affecting the public, the profession and physicians as individuals will arise, and may be decided, in 1945.

Each local medical society will be called upon to make decisions on which the policies of the medical profession on questions of public interest will be based. These decisions will guide the Ohio State Medical Association in its activities.

Each local medical society will be called upon to shoulder additional responsibilities; to engage in intensive public relations. Each society will be expected to keep its members informed on important events and developments affecting the medical profession. It will be expected to provide leadership for the profession.

These responsibilities can be met and efficient leadership provided if each local society will select its officers carefully; if alert and qualified members are chosen for committee assignments. Unless this policy is followed, the influence and activities of the society will be negligible.

The members of a medical society have a right to expect action and leadership from its officers and committeemen. At the same time, the members are at fault if the wrong men are selected for these positions. In the final analysis, the first step in keeping the society active, or revitalizing it, must be taken by the members themselves through the selection of the right men for the jobs.

This is the first obligation which faces each member of the Ohio State Medical Association on the eve of 1945—a year which will offer many challenges to the unity, strength and ability of the medical profession.

The officers, Councilors and committeemen of your State Association desire to expand the activities and influence of the state society; to keep it functioning in a way that will yield needed services and substantial benefits to its members.

This can be done if each local society is strong and if each local society will continue to give the officers, Councilors and committeemen of the State Association their united support.

The Council,
Ohio State Medical Association

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providing benefits on a service basis. Dr. Rothenberg reported that the committee had given careful consideration to a proposal for the organization of a mutual insurance company to provide medical, surgical and obstetrical coverage on a cash indemnity basis, with the activities of such company correlated with the activities of the Blue Cross Hospitalization programs operating in the Columbus and Cincinnati areas. Dr. Rothenberg stated that the committee did not favor the organization of a mutual insurance company for this purpose. He and other members of the committee pointed out the basic reasons for this conclusion of the committee.

Dr. Rothenberg then informed The Council that it was the unanimous opinion of his committee that immediate steps should be taken by the medical profession of Ohio to provide a practical means for offering medical coverage on a prepaid cash indemnity basis to the people of Ohio and that, therefore, the committee desired to offer the following recommendation to The Council:

"That the Ohio State Medical Association take the initiative in bringing about the organization of a stock insurance company to write medical coverage on a cash indemnity

basis, the control of such stock company to reside in the medical profession of Ohio."

After a prolonged discussion, on **motion** by Dr. Messenger, seconded by Dr. Harding, and **carried**, this recommendation of the committee was **adopted** by The Council.

Dr. Rothenberg then presented a second recommendation of his committee, namely:

"That The Council authorize the Committee on Medical Service Plans, on behalf of The Council, to enter into negotiations immediately with the Blue Cross Hospitalization Plans in an effort to arrive at mutually satisfactory arrangements to implement the organization and operation of the stock insurance company which would be established by the medical profession."

On **motion** by Dr. Lincke, seconded by Dr. LeFever, and **carried**, this recommendation was **approved** and the committee was instructed to confer immediately with the Blue Cross Directors and their Boards of Directors of the Columbus and Cincinnati areas on this matter.

On **motion** by Dr. Dixon, seconded by Dr. Messenger, and **carried**, The Council authorized the appropriation of $2,500.00 to be utilized by the Committee on Medical Service Plans for initial activities with respect to the organization of a stock insurance company, legal and actuarial counsel, etc., and that such amount be inserted in the 1945 budget of the Ohio State Medical Association.

For further details on action of The Council on the question of sponsoring the organization of a medical expense insurance company see page 1169.

POLICY ON INDUSTRIAL FIRM'S PLAN

A communication from the Hempstead Academy of Medicine, Scioto County, asking for the advice of The Council on a proposal made to the Hempstead Academy of Medicine by a Portsmouth manufacturing company, was read and discussed. The proposal was that the physicians of Scioto County should agree to provide surgery for employes of the company and their families under a standard fee schedule and that such fees would be paid direct to the physician by the company.

This question was discussed in detail by members of The Council and members of the Committee on Medical Service Plans. The Council expressed itself as being sympathetic with the motives of the Portsmouth company in its efforts to assist employes of the company in meeting the costs of surgical care. However, members of The Council felt that the methods proposed were not in line with the basic principles and policies of the medical profession in that they would permit the company to establish a maximum fee schedule for private practice and would be an interference with the direct relationship between the patient and the physician.

On **motion** by Dr. Sherburne, seconded by Dr. Harding, and **carried**, The Council adopted the following statement of policy on this question:

"That The Council recommends to the Hempstead Academy of Medicine that if the Hempstead Academy of Medicine favors the general idea of the proposal, it accept the proposal only as a cash indemnity plan and with the understanding that such benefits would not in any sense of the word be regarded as a fee schedule or as payment in full for services rendered."

BUDGET FOR 1945 ADOPTED

The Council then went into executive session for the purpose of considering a report of the Auditing and Appropriations Committee, including recommendations as to the 1945 budget of the State Association.

On **motion** by Dr. Micklethwaite, seconded by Dr. Knoble, and **carried**, the following budget for 1945, as recommended by the Auditing and Appropriations Committee, was **adopted**.

BUDGET FOR 1945

The Ohio State Medical Journal	$10,000
Executive Secretary, Salary	7,000
Executive Secretary, Expense	1,000
Asst. Exec. Secretary, Salary	5,500
Asst. Exec. Secretary, Expense	800
Stenographers	4,740
President, Expense	500
Council, Expense	900
Committee on Public Relations	6,000
Committee on Industrial Health	800
War Participation Committee	200
Committee on Education	1,500
Committee on Medical Service Plans	2,500
Miscellaneous Committee Expense	200
Committee on Auditing and Appropriations	100
A.M.A. Delegates, Expense	300
Stationery and Supplies	1,200
Postage, Telephone, and Telegraph	2,300
Rent, Insurance, and Bonding	2,800
Annual Meeting	3,800
Total	$52,140

RETIREMENT PLAN DISCUSSED

The Auditing and Appropriations Committee reported that it had given very thorough consideration to several proposals submitted by insurance companies for a retirement plan for employes of the State Association. Dr. Rutledge, chairman of the committee, informed The Council that it was the recommendation of the committee that, while the committee is favorable to

the general idea of a retirement plan for employes of the Columbus office, it feels that it would not be feasible for the Association to establish such a program at this time and suggests that the question be held over for further consideration by The Council, perhaps in December, 1945. On **motion** by Dr. Knoble, seconded by Dr. Sherburne, and **carried**, this recommendation of the committee was **approved.**

PLANS FOR 1945 ANNUAL MEETING

On behalf of the Committee on Scientific Work, the Executive Secretary reported that a tentative program and time schedule had been drafted for the 1945 Annual Meeting, Tuesday, Wednesday and Thursday, May 1, 2 and 3, at the Neil House and the Deshler-Wallick Hotel, Columbus. The Neil House was designated as the headquarters hotel and will house the technical exhibits and the registration headquarters. All general sessions also will be held at the Neil House. Some section sessions and special society meetings will be held at the Deshler-Wallick Hotel. Complete details on the program will be submitted to The Council at a later date and will be published in *The Journal.* On **motion** by Dr. Sherburne, seconded by Dr. Rutledge, and **carried**, the program and schedule as submitted by the committee were **approved.** In approving the report The Council approved a recommendation of the committee that a special sub-committee to work with the Committee on Scientific Work be appointed to assist in plans for the centennial meeting of the Ohio State Medical Association in 1946.

STATEMENT ON SYPHILIS

There was a general discussion of The Council on some of the articles appearing in newspapers and magazines in recent months regarding the so-called rapid treatment methods for curing syphilis. Believing that some of these articles have left a false impression with the public, The Council, on **motion** by Dr. Lincke, seconded by Dr. Rutledge, and **carried**, **adopted** the following statement of policy on this matter and instructed the Executive Secretary to send copies to all Ohio newspapers and other periodicals:

"With considerable trepidation, members of The Council of the Ohio State Medical Association have read some of the colorful articles which have appeared recently in some newspapers and magazines regarding the so-called 'rapid treatment' methods for curing syphilis.

"These popular writings have left the impression with the general public that syphilis is no longer to be regarded seriously.

"Such writers appear to have overlooked the fact that articles of this kind may tend to develop an attitude of promiscuity among formerly fearful individuals to such an extent that the number of cases of syphilis may increase rather than decrease.

"A well-founded respect for the ravages of this disease has, to a certain extent, been an effective deterrent to promiscuity and to the evolution of an unhealthy philosophy of sex conduct. Now, however, there appears to be a real danger that youth may assume the attitude, 'Why worry, we can be cured in a day'.

"Obviously, the development of rapid treatment centers for the treatment of syphilis and the results of such treatment are being watched with interest—and hopefully—by the medical profession and public health authorities. Nevertheless, these newer methods still are regarded as being in the experimental stage. Generally, satisfactory results are being obtained, but not without considerable risk to the patient, and as yet there has not been time for a thorough evaluation of the efficacy of this form of treatment.

"Eradication of this disabling and killing disease still is, and always should be, the goal toward which the medical profession and the public should aim. The building up of a feeling of undue optimism in the effectiveness of present 'quick cure methods', may retard, rather than stimulate, progress toward controlling, and eventually eliminating syphilis.

"Newspaper and magazine articles on matters of public health, personal hygiene and medical discoveries have been important factors in the diversified activities that have produced America's present favorable health record.

"Such educational activities have been encouraged by the medical profession. They should be continued. However, it is the sincere opinion of The Council of the Ohio State Medical Association that the original aims of efforts to provide the public with sound information on health questions will be defeated unless a more conservative attitude is taken by certain writers, both lay and medical, in articles produced by them for public consumption.

"The danger inherent in popular current writings on syphilis is just one example of how well-meaning aims can be defeated through emotional, sensational presentations of subjects which should be treated in a conservative, scientific manner."

MISCELLANEOUS

Legislative Proposals—Several suggested bills presented by Mr. C. B. Craig, Cincinnati, chairman of the Christian Science Committee on Publication for Ohio, proposing amendments to the Ohio Medical Practice Act, which would exclude from the provision of the act persons administering to human ills by prayer or spiritual means, were considered by The Council. The Council felt that these proposals required detailed analysis so, on **motion** by Dr. Sherburne, seconded by Dr. McNamee, and **carried**, they were referred to the Committee on Public Relations for study and a report back to The Council at its next meeting.

Tuberculosis Program—A communication from Dr. Carl A. Wilzbach, Cincinnati, a member of an Advisory Committee on the Co-Ordination of Tuberculosis Programs for Ohio of the Ohio Department of Health asking the Ohio State Medical Association to cooperate in improving tuberculosis activities in the State of Ohio and to consider a number of definite proposals recom-

mended by the Advisory Committee, was discussed. On **motion** by Dr. Knoble, seconded by Dr. Swartz, and **carried**, this matter was referred to the Committee on Public Relations for consideration and recommendation, The Council believing that the matter required more study than could be given to it by The Council at this meeting.

Promotions in the Navy—The President, Dr. Schriver, was authorized by The Council to make an investigation of a report that promotions in the Medical Corps, U. S. Navy Reserve, had been frozen and to take whatever action he might deem advisable on this matter.

Taxation Question—A communication from the National Tax Equality Association, on **motion** by Dr. Swan, seconded by Dr. Rutledge, and **carried**, was referred to the Committee on Public Relations and Economics.

Amendments Discussed—On **motion** by Dr. Rutledge, seconded by Dr. Swartz, and **carried**, the Judicial and Professional Relations Committee was requested to make a study of the advisability of amending the Constitution and By-Laws of the State Association on the matter of membership qualifications with respect to physicians employed at Veterans' Administration hospitals in Ohio or other government institutions and to submit a report to The Council at its next meeting.

Council Commended—A letter from the Cleveland Otolaryngological Club, commending The Council and the Committee on Workmen's Compensation on the report submitted to the Ohio Industrial Commission, was read.

Message to Membership—A special message from The Council to the membership, emphasizing to county medical societies the importance of electing well-informed officers and committeemen for 1945, which may be one of the most critical periods in the history of medical organization, was **adopted**, on **motion** by Dr. Lincke, seconded by Dr. Swartz, and **carried**, with instructions that the message be published in a prominent place in the December issue of *The Ohio State Medical Journal.*

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

Civilian physicians and medical officers in the armed forces are invited to attend a War-Time Graduate Medical Meeting, sponsored by the American Medical Association, American College of Physicians and the American College of Surgeons, to be held at the Crile General Hospital, Cleveland, Dec. 12. Dr. James A. Dickson, Cleveland, will speak on "Bone Grafting".

Seventh Annual Forum on Allergy To Be Held in Pittsburgh, Jan. 20-21

All Ohio physicians are cordially invited to attend the Seventh Annual Forum on Allergy at the Hotel William Penn, Pittsburgh, Saturday and Sunday, Jan. 20 and 21, 1945. This is a meeting to which all reputable physicians are most welcome, and where they are offered an opportunity to bring themselves up to date in this rapidly advancing branch of medicine by two days of intensive postgraduate instruction. For instance, the twelve study groups, any two of which are open to him, are so divided that those dealing with ophthalmology and otolaryngology, pediatrics, internal medicine, dermatology and allergy run consecutively. In addition, the study groups are arranged on the basis of previous registration. In this way, as soon as the registrations are completed, the registrant is expected to write the group leader and tell him just what questions he wants brought up in the discussion. Attention is also called to the fact that during these two days almost every type of instructional method is employed—special lectures by outstanding authorities, study groups, pictures, demonstrations, symposia and panel discussions.

On Friday evening preceding the Forum the American Association of Allergists for Mycological Investigation will hold its annual meeting at which time the results of their cooperative research on the Allergy to Fungi will be reviewed. All reputable physicians and scientists are invited to attend this interesting summarization of a year of brilliant cooperative research.

For further information and registration, write Jonathan Forman, M. D., Director, 956 Bryden Road, Columbus 5.

Three Physicians Elected at Recent General Election

Dr. Frederick C. Smith, Marion, was re-elected to the U.S. Congress by the voters of the Eighth Ohio Congressional district on Nov. 7. Two physician-members of the Ohio House of Representatives, Dr. E. LeFever, Glouster, and Dr. C. A. Craig, Cambride, also were re-elected. Dr. LeFever, unopposed this time, will be representing Athens County for the sixth time in the legislature. He has also served 12 years in the State Senate. Dr. H. V. Dutrow, Dayton, was unsuccessful in his campaign to become one of Montgomery County's representatives in the legislature. All four candidates are Republicans.

Dr. Morris Fishbein, Editor of *The Journal of the American Medical Association*, spoke on "Unattained Goals in Medicine", at the fourth anniversary luncheon of the Cleveland Health Museum, Nov. 14.

Organization of Medical Expense Insurance Company by Ohio Physicians Proposed; Negotiations Started

PLANS and negotiations pointing toward the organization by the physicians of Ohio of a stock insurance company to write surgical, obstetrical and perhaps medical coverages on a cash indemnity basis have been initiated by The Council of the Ohio State Medical Association. **(See minutes of meeting of The Council, held on November 12, pages 1164-1168.)**

Recognition of the need of many Ohio families for protection against the costs of medical service on a prepayment basis, prompted The Council's action, after reviewing recommendations made by the Committee on Medical Service Plans following meetings and conferences extending over a period of several months.

THINK SERVICE BASIS NOT FEASIBLE

The Council agreed with the committee that there are insurmountable obstacles at present to the organization of a medical plan on a service basis under the Ohio Enabling Act, enacted in 1941. Also, The Council agreed with the committee that control of any medical care plan should be vested in the medical profession which would not be possible under a mutual insurance company. Under the type of company approved by The Council, control would be in the hands of physicians subscribing to and holding the shares of stock.

Success of Blue Cross hospitalization plans in Ohio which now cover approximately 2,000,000 persons for hospital costs on a prepayment basis has indicated two things, The Council felt: First, that many Ohioans would be interested in budgeting the costs of medical care on a prepayment basis if a suitable plan could be set up and, second, that there should be close cooperation with the Blue Cross plans on matters relating to the sale of the medical coverage in connection with Blue Cross contracts, auditing, accounting, and other administrative details.

WILL CONFER WITH BLUE CROSS

The Council has authorized the Committee on Medical Service Plans to confer immediately with Blue Cross officials in an effort to arrive at mutually satisfactory arrangements to carry on the activities of the medical expense insurance company when organized and chartered by the Ohio Insurance Division.

Benefits which would be provided by the policy offered by the contemplated medical expense insurance company would be in the form of cash in conformity with a definite schedule of benefits. The benefits would not establish the physician's fee but would provide the subscriber with a certain amount of money to be applied by him toward payment of his physician for services rendered. Subscribers would have free choice of physician. It is contemplated that after cash reserves required by the state insurance laws have been set aside, all money received from premiums would be paid out to subscribers in the form of benefits.

Additional information on this project which has the approval of The Council will be published in *The Journal* after the conferences with the Blue Cross officials have been held and more details with respect to the organization of the company have been worked out.

American College of Surgeons Expands Training Program

In expanding its program of Graduate Training in Surgery to assure adequate opportunities for advanced training in surgery, particularly for recent medical graduates when they return from service with the armed forces, the American College of Surgeons has enlarged its headquarters staff in Chicago and announces the following new appointments effective immediately:

Major General Charles R. Reynolds (M.C., Retired), former Surgeon General of the U.S. Army, has been appointed Consultant in Graduate Training in Surgery. He has been director of the tuberculosis control program of the Pennsylvania State Health Department for the past four years.

Dr. George H. Miller, formerly Dean of the Faculty of Medicine and Chairman and Professor of the Department, American University of Beirut, Lebanon, Syria, has been appointed Director of Educational Activities.

The Department of Graduate Training in Surgery is under the general direction of Dr. Malcolm T. MacEachern, Chairman of the Administrative Board, working with that Board, and responsible to the Committee on Graduate Training in Surgery, of which Dr. Dallas B. Phemister of Chicago is Chairman, and to the Board of Regents. In addition to General Reynolds and Dr. Miller, the staff of the department consists of Dr. Paul S. Ferguson, Director of Surveys, and three assistants who conduct the surveys; and the field representatives conducting the regular Hospital Standardization surveys under the direction of Dr. E. W. Williamson, Assistant Director of the College, who assist as required in the graduate training program.

Dennison—Dr. W. W. H. Curtiss spoke on "Roots and Herbs in the Practice of Medicine", at a meeting of the Rotary Club.

Navy Appeals for 3,000 Additional Medical Officers As Recruitment for Army Medical Corps is Discontinued

RECRUITMENT of civilian physicians for the Army Medical Corps has been discontinued but recruitment of physicians for the Navy Medical Corps will continue, according to an announcement made by Paul V. McNutt, chairman of the War Manpower Commission under which the Procurement and Assignment Service for Physicians operates.

Also, recruitment of physicians for the U. S. Public Health Service and the Veterans' Administration will continue.

The Army at the present time has on active duty approximately 47,500 physicians, including those assigned to the Veterans' Administration and to other governmental agencies, and will not consider the commissioning of physicans from civilian life who were not declared available by the Procurement and Assignment Service prior to October 20, 1944.

STUDENTS, INTERNS AND RESIDENTS

Any medical student, intern or resident who is commissioned in the Army Medical Corps, in the Medical Administrative Corps, or is a student under the Army Specialized Training Program, will be expected to serve in the Army as soon as he becomes qualified for assignment to active duty. Those who do not meet the Army physical requirements may be assigned to the Veterans' Administration.

Any medical graduates, interns, or residents, who are not already commissioned will not be asked to apply for commission in the Army, but their applications for commission in the Navy Medical Corps will be considered.

The Army may continue to request occasional availabilities for specific position vacancies in cases of physicians who have been highly desirous of service or who are now or in the future available for the first time because of replacement, returning veterans, etc.

NEED OF NAVY IS ACUTE

In announcing that the recruitment of physicians from civilian life for the Navy Medical Corps and the commissioning of medical students, interns and residents for the Navy Medical Corps must continue, Mr. McNutt pointed out that Vice Admiral Ross T. McIntire, chief of the Bureau of Medicine and Surgery, U. S. Navy, has informed the War Manpower Commission that personnel expansion and intensification of operations in the Pacific have precipitated a grave shortage of medical officers in the Navy.

With less than 13,000 medical officers on active duty in the Navy, the procurement of at least 3,000 more as soon as possible is imperative, according to Admiral McIntire. Even this figure will not meet actual needs but would ease the emergency that now exists; physicians and surgeons whose availability has been or may hereafter be certified by the Procurement and Assignment service, WMC, should lose no time in obtaining particulars for commissions in the Navy Medical Corps by communicating with their nearest office of Naval Officer Procurement, McIntire pointed out.

Mr. McNutt said he had been informed that the Army will fill its future requirements for military physicians from sources now available to the Army and thereafter will not require certification of availability of additional physicians from the Procurement and Assignment Service of the War Manpower Commission.

ABOUT 60,000 IN SERVICE

Mr. McNutt said that there are at present roughly 60,000 physicians in the armed forces and the Veterans' Administration. The total number of physicians in the armed forces represents approximately 40 per cent of the active medical profession of the United States.

In addition to the 3,000 medical officers needed at present by the Navy, the Public Health Service has need for approximately 300 for the U. S. Coast Guard and other agencies.

In informing Mr. McNutt of the termination of the Army recruiting of physicians except for the occasional specialist, Major Gen. Norman T. Kirk, Surgeon General of the Army, said:

WHERE TO APPLY FOR NAVY

Ohio physicians desiring to apply for a commission in the Medical Corps, United States Naval Reserve, and who are cleared as available by the Ohio Procurement and Assignment Committee, should get in touch with the Office of Naval Officer Procurement, 9th Floor, Book Building, 1249 Washington Blvd., Detroit 26, Michigan, or with the Office of Naval Officer Procurement, Enquirer Building, Room 933, 617 Vine Street, Cincinnati.

The Cleveland and Columbus offices of the Office of Naval Officer Procurement have been closed.

Those applying will have to be declared as available by the Procurement and Assignment Service before their applications will be processed.

"The largest number of physicans now in the Army volunteered for commissions without regard for personal interests. The U. S. Army Medical Department is appreciative of the fine service they have given. Their removal from their usual practice also represents a sacrifice on the part of all civilians, who have had to get along with less medical care than they obtained in peacetime."

PROFESSION IS LAUDED

The Veterans' Administration has, and will continue throughout the duration of the war emergency to have, assigned to it medical officers in the Army and the U. S. Naval Reserve to care for the needs of the casualties in its charge, the War Manpower Commission said. Doctors whose applications are at present in process for appointment in the Army Medical Corps will be considered for appointment and assignment to duty with the Veterans' Administration, the War Manpower Commission statement added.

Mr. McNutt said that the War Manpower Commission joins with the directing board of its Procurement and Assignment Service and the War Department and the Office of the Surgeon General in expressing appreciation of the sacrifice involved in cooperation that was necessary on the part of physicians and the public before the Army reached its present level of medical personnel.

Skilled Aides To Fight Polio Needed; Training Courses Offered

The 1944 epidemic of infantile paralysis has officially become the second worst in the recorded history of the disease in the United States, it has been announced by Basil O'Connor, president of The National Foundation for Infantile Paralysis. At the same time, Mr. O'Connor stressed the need for more skilled polio fighters, especially physical therapists, and urged that men and women who have the proper qualifications make applications for scholarships offered by the National Foundation and its Chapters.

In the first 41 weeks of 1944, or up until October 14, there were 16,133 cases of poliomyelitis, according to the latest report from the U.S. Public Health Service. This is 353 cases more than were reported in the country for 1931 which previously had been the second worst year for the disease. The all-time record was in 1916 when there were 27,621 cases.

Scholarships sponsored by the National Foundation are available to graduate nurses, graduates in physical education or those with a minimum of two years undergraduate college work with science courses. Such applications may be made through the National Foundation or to The American Physiotherapy Association, 1790 Broadway, New York 19, N.Y.

Four Added to Regular Staff of the Cleveland Clinic

On January 1, 1945, the staff of the Cleveland Clinic will be augmented by four members. Dr. L. W. Diggs, associate professor of medicine at the University of Tennessee College of Medicine, will become Clinical Pathologist and will assume charge of the clinical laboratories. A graduate of Johns Hopkins University Medical School, Dr. Diggs spent three years in the Department of Medicine at the University of Rochester. His major work and interest has been in sickle cell anemia.

Dr. Irvine H. Page, Director of the Lilly Laboratory for Clinical Research at the Indianapolis City Hospital, has been appointed Director of Research at the Clinic. Dr. Page is a graduate of Cornell University Medical College, and before going to Indianapolis had been successively Director of Clinical Division, Kaiser Wilhelm Institute, Munich; and associate, Rockefeller Institute, New York City. He has been a large contributor to medical literature, chiefly relative to cardiovascular-renal disease.

Two other members of the staff of the Lilly Laboratory for Clinical Research, Dr. A. C. Corcoran and Dr. R. D. Taylor, have accepted appointments to the staff of the Research Division of the Clinic. Dr. Corcoran, a graduate of McGill University Faculty of Medicine, formerly was associated with the Department of Metabolism, Montreal General Hospital and with the hospital of the Rockefeller Institute. Dr. Taylor is a graduate of Northwestern University Medical School and interned at Passavant Hospital. Dr. Corcoran's special interest has been in renal function, and that of Dr. Taylor has been in the clinical study of hypertension.

Urological Essay Prize

The American Urological Association offers an annual award, not to exceed $500, for an essay (or essays) on the result of some specific clinical or laboratory research in urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deems none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. All interested should write the secretary for full particulars. The selected essay (or essays) will appear on the program of the forthcoming June meeting of the American Urological Association. Essays must be in the hands of the secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tenn., on or before March 15, 1945.

Cleveland East Ohio Gas Company Disaster Shows Value of Well-Organized Emergency Medical Program

ROSCOE D. LEAS, M.D., CLEVELAND, OHIO
Medical Chief, Civilian Defense Emergency Medical and First Aid Services

THE afternoon of Friday, October 20, was warm with scarcely a breeze to disturb the autumn haze. War plants were humming, and Clevelanders were going their various busy ways. At 2:34 a concussion was felt by many people in the Greater Cleveland area, and some were knocked from their feet. For the most part, everyone continued at work, not realizing that the city was being plunged into one of the worst disasters in its history.

On the northeast shore of the lake a huge column of flame and smoke arose. A second explosion followed after a short interval, and an area bounded by East 55th Street, East 65th Street, St. Clair Avenue and Lake Court—about 50 city blocks—became a mass of burning wreckage.

Two of the East Ohio Gas Company storage tanks, containing gas in a liquid state at a temperature of 250° below zero, had exploded.

CRATERS TORN IN STREET

Those are dead who might have explained the blast. A supposition is that one tank began to leak, the liquid vaporized and then was ignited. A sheet of flame enveloped the entire district, setting fire to homes, stores and manufacturing plants.

During several hours following the initial blast, manhole covers were blown out, and large craters were torn in the streets as a result of exploding gas which had seeped into underground installations.

Fifty-three persons were burned beyond identification. Many had harrowing experiences and sustained severe or minor burns.

In the largest group of cases apparently the intense heat, and not the actual flame, produced scalp and skin burns without injuring the hair or clothing. Wounds from flying glass constituted the next major group. Although the concussions were severe, none was found with injuries similar to those following bomb explosions.

The extent of the disaster was not realized at first, consequently the protective services were not mobilized for about one-half hour. All branches of O.C.D. performed in such an orderly and efficient manner that anyone who doubted the usefulness of the Civilian Defense Organization in an emergency, immediately had his skepticism dispelled.

FUNCTIONING OF MEDICAL UNITS

Our readers will be most interested in the functioning of the medical units of O.C.D. and American Red Cross. O.C.D. Medical, with a few exceptions, was designed according to the instructions of the Fifth Service Command. It has maintained its staff of doctors, nurses, control centers in the thirty report areas in Greater Cleveland, with casualty stations and hospital organizations. A smaller, more compact, section of this organization was designed for a rapidly functioning organization in case of sabotage.

The American Red Cross dovetailed with the above groups through the medical division of its Disaster Corps. At the time of the disaster, plans were under way for the absorption of O.C.D. Medical by the American Red Cross, at such time as the Federal Government should declare O.C.D. no longer essential. Leadership of the three groups was vested in the same individual.

It may be interesting to other defense organizations to learn how ours functioned under stress after so much planning and so little opportunity to test theories.

At 3:18 P.M. the medical chief was notified of the disaster by 'phone. This was the first step of organization of medical activities and resources.

The Academy of Medicine of Cleveland and Cuyahoga County was alerted, and functioned, as planned, as the nerve center of O.C.D. Medical. It alerted:

PROCEDURES OUTLINED

First, the medical teams of University Hospital, Huron Road and Charity Hospitals.

Second, the Cleveland Automobile Club, in

EDITOR'S NOTE: The accompanying article was written for The Ohio State Medical Journal at the request of the Editor. The primary purposes of the article are: (1) to show why all communities, especially metropolitan areas, should maintain an alert and well-organized emergency medical and first-aid services to cope with community disasters; (2) to record the good points in the setup which functioned in Cleveland at the time of the East Ohio Gas Company tragedy; (3) to reveal defects in the program of caring for the injured which can be taken into account by officials of emergency medical setups in other areas of the state and proper adjustments made immediately. The Journal is indebted to Dr. Leas for his excellent presentation.

order that ambulances be sent to convey medical teams to the scene.

Third, Dr. Edward P. Judd, the coordinator of activities at the Academy.

Dr. Judd arrived at his post about five minutes after being alerted and, according to plan, proceeded as follows:

1. Alerted all hospitals in Cuyahoga County, which, in turn, began mobilizing their emergency staffs of doctors, nurses, technicians, dietitians and maintenance men.
2. Made a survey of emergency bed space in each hospital.
3. With the competent assistance of Mr. Lloyd Chatterton (Communications Officer of the Cleveland Police Department, and an important key man in O.C.D.) began dispatching the injured to hospitals through police cruisers which were equipped with radio, in communication with a dispatch car at the scene.

OPERATION OF CASUALTY STATIONS

The medical chief established quarters in a casualty station in Area 2, the location of the disaster. Four adequately equipped casualty stations were manned by the hospital teams which arrived between 3:45 and 4:00 P.M. Each team carried with it A. and B. Civilian Defense kits. Volunteer services were also rendered by a group of doctors from Crile General Hospital, and one from the Naval Training School (Diesel).

Telephonic communications were disrupted over a wide area, giving opportunity to test another plan. A police cruiser, equipped to send and receive by radio, was instructed to stand by the medical chief, as was a similar unit from the American Red Cross. Thus at all times there was direct communication with the main control center, the Academy of Medicine and Red Cross Headquarters.

By 4:30 P.M. order prevailed. There was an even distribution of the injured to the hospitals. As an example, Charity Hospital 'phoned that its accident ward was about overwhelmed with cases. The message was relayed to the main control center and thence to police cruisers. Proof that the system worked was soon forthcoming when Charity called to inquire why it was receiving no more injured.

DEAD AND INJURED

The definitely known number of injured was 357. Of these, 179 were treated in hospitals; 73 were hospitalized. The dead numbered 129. Many unrecorded injured were treated at casualty stations and shelters.

In view of the extent of the disaster, the number of dead and injured was remarkably small. At no time was there a question as to the adequate handling of the injured; at no time were facilities overtaxed except early in the disaster; and at no time was there a lack of emergency beds—in fact, we came to the end of the crisis in readiness for 200-300 more patients than were admitted.

The fire was in only one area (Area 2); but it was out of control at first, and the probability of explosion of other gas tanks was a definite menace throughout the night. Therefore, the main control center alerted and mobilized the personnel, including doctors and nurses in sixteen report areas (1-15 and 19).

RED CROSS WORK VALUABLE

Red Cross first-aid teams performed valuable rescue and first-aid work and, in addition, helped to reunite families and direct the homeless to shelters. Nurse's aides were found to be well trained and proved a valuable adjunct to the medical service.

Red Cross Blood Donor Service was alerted, again according to O.C.D. plan, and its personnel remained on duty during the early part of the evening. Services of this branch were not needed because of the adequate store of plasma in the various hospitals. O.C.D. and Red Cross plasma was used, and in numerous instances the independent blood banks of the hospitals were utilized. The treatment of severe burns varied, but of course plasma was used for all. No new development in the technique of handling burns was reported.

OTHER GROUPS PRAISED

Smoothness of operation of the medical service was made possible only through the cooperative efforts of its own and related branches of O.C.D. and the Red Cross. An ample share of credit goes to Mr. John Young of the Cleveland Automobile Club, whose organization furnished rapid and adequate transportation for doctors, nurses and the injured.

It remains for others to give deserved credit to various individuals and organizations. Briefly, however, a few should be mentioned. The handling of emergency is a duty of City Police and Fire Departments, but in this instance the services rendered were beyond the usual routine and deserve special commendation. Units of the Army, Navy and Coast Guard, aided in policing the area, and the last-named gave effective help in fighting the fire. Radio Station WGAR's mobile unit served as an emergency communication center early in the crisis.

It is taken for granted that the Red Cross always does a good job, and it, therefore, does not receive all the credit due it. Not only did it enter into the activities, as outlined above, but carried on during and after the fire. Representatives of National and Eastern Area Headquarters arrived the day following the disaster, to aid the Greater Cleveland Chapter in the problems of shelter for the homeless, follow-up nursing and medical care, and money where it was

necessary. This part of the work is still progressing; and the homeless and injured have found a valuable friend in the organization.

DEFECTS IN PLAN

Experience disclosed defects which are being remedied. Too many cases were sent to hospitals which could have been adequately cared for in the field. The hospitals and transportation system could have been overtaxed had the number of cases been greater. For this reason, casualty stations need to be more clearly marked; and it is proposed that a large Red Cross flag be made a part of the equipment of the hospital teams. This flag should be displayed prominently on arrival of a team at its station, and Police and Fire Departments should be instructed as to its significance.

The Red Cross also needs a mobile public address system to better coordinate its medical and other activities at the scene.

This disaster, that of Boston and others, prove the need of a well-coordinated medical protective organization, in addition to the Police and Fire Departments, particularly in large cities. The Red Cross has served in this capacity, but never before has had such a well-trained group as O.C.D. Medical.

In Cleveland we are hoping to incorporate much of O.C.D. Medical in the Disaster Corps of the American Red Cross. The groups functioned so well that, in our opinion, a much larger catastrophe could have been handled, if necessary.

Nobel Prize Winners

Announcement has been made from Stockholm of the winners of the 1943 and 1944 Nobel prizes in physiology and medicine. The 1943 award was made to Drs. Edward A. Doisy, professor of biochemistry at the St. Louis University School of Medicine, and Henrik Dam, Copenhagen, now assistant professor of biochemistry at the University of Rochester School of Medicine and Dentistry, Rochester, N.Y., for their fundamental investigations on the chemical nature of vitamin K. The 1944 award was presented to Drs. Joseph Erlanger, professor of physiology, Washington University School of Medicine, St. Louis, and Herbert Spencer Gasser, director of the Rockefeller Institute, New York, for their studies on the function of individual nerves. The annual prizes are worth about $29,000 and will be divided among the winners.

Columbus—In a two-day swing through Guernsey, Noble and Monroe counties, Dr. Jonathan Forman spoke on "Health From the Soil", before 12 different groups, including the Cambridge Rotary Club, high school, farm and conservation organizations.

Dr. Cronick To Head New Youngstown Mental Disease Hospital

Dr. C. Herbert Cronick, Youngstown psychiatrist, has been appointed medical director of the Youngstown Receiving Hospital for Mental Cases. Formerly the city contagious disease hospital, the institution has been leased by the State Department of Public Welfare and is being remodeled to treat early mental cases. It has been estimated that about 400 persons can be treated at the hospital yearly, with no treatment exceeding 12 weeks. Patients needing more treatment will be transferred to Massillon State Hospital. The Youngstown Hospital will be under the direction of Dr. Arthur G. Hyde, superintendent of the Massillon State Hospital.

Formerly a captain in the Medical Corps of the Army of the United States, Dr. Cronick was recently given an honorable discharge. He had been in the Army since June, 1942, with service at Moody Field, Va., and Maxwell Field, Ala. Dr. Cronick graduated at the University of Pennsylvania Medical School in 1936, and following two years as assistant resident in neuropsychiatry at the Cleveland City Hospital, one year in psychiatric work at the Institute of Pennsylvania Hospital, Philadelphia, and a teaching fellowship in child guidance at the University of Indiana, was in private practice in Youngstown prior to being commissioned in the Army.

New Council on Rheumatic Fever

The Council on Rheumatic Fever has been formed to focus attention on the problem of rheumatic fever. Organizations comprising membership include: the American Medical Association, American College of Physicians, American Rheumatism Association, American Academy of Pediatrics, American Public Health Association, American Hospital Association, American Association of Medical Social Workers, and the American Heart Association. According to *The Journal of the A.M.A.*, negotiations are in progress with officers of the American Legion in the hope that the Legion may accept the responsibility for the financial support of the council on a national scale.

Drs. George X. Schwemlein, Cincinnati, and R. M. Craig, Dayton, reserve officers in the United States Public Health Service stationed at the Chicago Intensive Treatment Center, spoke on "Recent Advances in the Treatment of Syphilis" at the American College of Physicians Postgraduate Course No. 5—Special Phases of Internal Medicine, October 28, at Thorne Hall, Northwestern University.

Military Roster Now Totals 3,103; Names of 63 Added During Month; Those Promoted Tabulated

SIXTY-THREE names were added to the Military Roster of the Ohio State Medical Association during the past month, making the total 3,103 of which 2,600 are in the Army, 431 in the Navy and 72 in miscellaneous governmental services. The names added this month were those of hospital interns and residents called to active duty.

Following are the names of those added to the Military Roster, those promoted and a breakdown of men in the services by counties.

NAMES ADDED TO MILITARY ROSTER

Name	City	Rank
Adams, Wendall, Wm.	Cleveland	Lt. (j.g.), U.S.N.
Barry, Ray W.	Elyria	1st Lt., U.S.A.
Becker, Norman O.	Cleveland	Lt. (j.g.), U.S.N.
Bell, Needham Eric	Cleveland	Lt. (j.g.), U.S.N.
Carlson, David John	Youngstown	Lt. (j.g.), U.S.N.
Cogswell, Robert	Cincinnati	1st Lt., U.S.A.
Cowgill, Joseph S.	Toledo	Lt. (j.g.), U.S.N.
Daley, James Bernard	Cleveland	1st Lt., U.S.A.
Davis, Christie E.	Youngstown	1st Lt., U.S.A.
Davis, John W.	Cleveland	1st Lt., U.S.A.
Dehn, Helmut M.	Cleveland	1st Lt., U.S.A.
Drury, Walter E.	Cleveland	1st Lt., U.S.A.
Faulkner, Donald	Cleveland	Lt. (j.g.), U.S.N.
Gecht, Eli	Cincinnati	1st Lt., U.S.A.
Gerrish, Edwin W.	Cleveland	1st Lt., U.S.A.
Goler, George	Cleveland	1st Lt., U.S.A.
Hamlin, Wyeth	Cincinnati	1st Lt., U.S.A.
Hancock Thomas J.	Cleveland	1st Lt., U.S.A.
Hanlon, Rollins	Cincinnati	Lt. (j.g.), U.S.N.
Helmsworth, James	Cincinnati	1st Lt., U.S.A.
Hines, Harry K.	Cincinnati	1st Lt., U.S.A.
Hubay, Charles	Cleveland	1st Lt., U.S.A.
Hunsberger, W. Glenn	Cincinnati	Lt. (j.g.), U.S.N.
Jacobs, Donald L.	Cincinnati	1st Lt., U.S.A.
Jentes, Paul	Columbus	1st Lt., U.S.A.
Johnston, Charles E.	Cincinnati	1st Lt., U.S.A.
Jurin, Benjamin	Cincinnati	1st Lt., U.S.A.
Kauffman, James	Columbus	1st Lt., U.S.A.
Keeling, Wm. H.	Cincinnati	1st Lt., U.S.A.
Klein, E. I.	Cleveland	1st Lt., U.S.A.
Kunnen, Albert	Cincinnati	1st Lt., U.S.A.
LaManna, John Robert	Youngstown	1st Lt., U.S.A.
Leary, Wm. Gordon	Cincinnati	Lt. (j.g.), U.S.N.
Lewis, Blaine, Jr.	Youngstown	1st Lt., U.S.A.
Macauley, James	Cleveland	Lt. (j.g.), U.S.N.
McMurrin, James	Cincinnati	Lt. (j.g.), U.S.N.
McWilliams, John E.	Toledo	1st Lt., U.S.A.
Moats, Dean Terry	Toledo	Lt. (j.g.), U.S.N.
Moffatt, Robert E.	Cleveland	1st Lt., U.S.A.
Murphy, Daniel M.	Cleveland	1st Lt., U.S.A.
Paschold, John Henry	Cleveland	1st Lt., U.S.A.
Pocock, Herman	Cleveland	Lt. (j.g.), U.S.N.
Pomrince, Simour D.	Warrensville	Lt. (j.g.), U.S.N.
Rack, Frank Joseph	Cleveland	1st Lt., U.S.A.
Radzow, Karl H.	Cleveland	Lt. (j.g.), U.S.N.
Robechek, Philip J.	Cleveland	Lt. (j.g.), U.S.N.
Roskos, Andrew T.	Cleveland	Lt., U.S.N.
Rothe, Wm. S.	Toledo	1st Lt., U.S.A.
Rowe, Richard J.	Cleveland	1st Lt., U.S.A.
Schaber, Jack F.	Youngstown	1st Lt., U.S.A.
Shea, Patrick	Cleveland	Lt. (j.g.), U.S.N.
Shelly, Wm. Patrick	Cleveland	1st Lt., U.S.A.
Shorten, Edward A.	Youngstown	Lt. (j.g.), U.S.N.
Shreve, Alfred J.	Cleveland	1st Lt., U.S.A.
Sigel, Harry	Cincinnati	1st Lt., U.S.A.
Suttles, Charles M.	Youngstown	1st Lt., U.S.A.
Smith, Quentin B.	Cleveland	1st Lt., U.S.A.
Strauch, James J.	Cleveland	Lt. (j.g.), U.S.N.
Wadsworth, Charles L.	Cincinnati	1st Lt., U.S.A.
Weller, Eli J.	Cincinnati	Lt. (j.g.), U.S.N.
Whiting, Lewis W.	Cleveland	1st Lt., U.S.A.
Wilke, Richard M.	Cleveland	1st Lt., U.S.A.
Wolf, Arthur F.	Cleveland	1st Lt., U.S.A.

WIN PROMOTIONS

Name	City	Rank
Bavor, Herbert J.	Berea	Capt., U.S.A.
Bowman, Robert E.	Cleveland	Lt. Col., U.S.A.
Budd, John H.	Cleveland	Capt., U.S.A.
Docter, Luebert	Toledo	Capt., U.S.A.
Dougherty, Clark M.	New Philadelphia	Lt. Col., U.S.A.
Fine, Archie	Cincinnati	Major, U.S.A.
Geiss, Ferdinand V.	Cleveland	Capt., U.S.A.
Humphries, Wm. C.	Cleveland	Capt., U.S.A.
Limbacher, Henry P.	Cleveland	Major, U.S.A.
Morton, Wallace	Toledo	Major, U.S.A.
Neff, Frank R.	London	Major, U.S.A.
Reedholm, E. A.	Akron	Capt., U.S.A.
Rheingold, Jack J.	Cincinnati	Capt., U.S.A.
Rusk, Ross P., Jr.	Cadiz	Capt., U.S.A.
Schumacher, Edw. R.	Columbus	Major, U.S.A.
Smith, Gordon A.	Elyria	Capt., U.S.A.
Vogelsang, Aaron D.	Toledo	Major, U.S.A.
Voorhis, Chas. C.	Cleveland	Major, U.S.A.

TABULATION BY COUNTIES

Adams 2	Guernsey 7	Muskingum .. 9
Allen 39	Hamilton 504	Noble 1
Ashland 12	Hancock 12	Ottawa 9
Ashtabula ... 18	Hardin 7	Paulding 2
Athens 10	Harrison 4	Perry 4
Auglaize 6	Henry 3	Pickaway 5
Belmont 14	Highland 7	Pike 2
Brown 4	Hocking 4	Portage 2
Butler 30	Holmes 2	Preble 7
Carroll 1	Huron 16	Putnam 6
Champaign ... 9	Jackson 1	Richland 38
Clark 38	Jefferson 29	Ross 24
Clermont 9	Knox 11	Sandusky ... 12
Clinton 8	Lake 18	Scioto 20
Columbiana .. 11	Lawrence 6	Seneca 12
Coshocton 4	Licking 17	Shelby 7
Crawford 9	Logan 8	Stark 101
Cuyahoga 786	Lorain 40	Summit 165
Darke 6	Lucas 181	Trumbull 27
Defiance 4	Madison 6	Tuscarawas .. 20
Delaware 7	Mahoning 141	Union 2
Erie 10	Marion 16	Van Wert.... 9
Fairfield 9	Medina 13	Vinton 2
Fayette 2	Meigs 3	Warren 4
Franklin 246	Mercer 6	Washington .. 8
Fulton 6	Miami 15	Wayne 14
Gallia 5	Monroe 1	Williams 8
Geauga 4	Montgomery .164	Wood 19
Greene 7	Morgan 3	Wyandot 3

Total 3103

Attend Chicago Conference

Speakers on the program of the Annual Conference of State Secretaries and Editors, held at Chicago, Nov. 17-18, under the auspices of the American Medical Association, included Dr. Robt. E. S. Young, Columbus, who spoke on "Medical Service Plans", and Dr. John W. Wilce, Columbus, who discussed "Medical Attitudes, Opportunities and Responsibilities in a National Fitness Program". The meeting was attended by Dr. Jonathan Forman, Editor of *The Ohio State Medical Journal*; Charles S. Nelson, Executive Secretary, and George H. Saville, Assistant Executive Secretary, of the Ohio State Medical Association, and George W. Cooley, executive secretary of the Toledo Academy of Medicine.

Pattern for Comprehensive Mental Hygiene Program for Ohio Drafted by Special Governor's Committee

A BROAD general outline for a minimum mental hygiene program for the State of Ohio is presented in a report transmitted to Governor Bricker on November 20 by the Governor's Committee on the Mental Health Program for Ohio.

Members of the committee are: Hal H. Griswold, Cleveland, chairman; Leonard W. Mayo, Cleveland, vice chairman; Dr. J. F. Bateman, Columbus; Dr. R. E. Bushong, Lima; Judge Charles E. Chittenden, Toledo; Judge Oscar Gast, Marion; Dr. W. W. Greulich, Cleveland; Dr. George T. Harding, Columbus; Dr. Arthur T. Hopwood, Apple Creek; Dr. Louis J. Karnosh, Cleveland; Bleecker Marquette, Cincinnati; Charles L. Sherwood, Columbus; Fred W. Schwenck, Cincinnati; and Judge Clifford M. Woodside, Youngstown. Mr. Raymond G. Fuller, of the research staff of the Ohio Institute, served as executive secretary.

The major findings and recommendations of the committee, described in detail in the report, are as follows:

INSTITUTIONAL FACILITIES

Present accommodations of the state for mental patients are seriously inadequate. Needed expansion requires not only more beds but more institutions.

Within the next ten years, the total bed capacity of state institutions should be increased approximately as follows:

For the mentally ill	from 16,500	to 30,000	or 35,000
For the epileptic	from 1,900	to 6,100	
For the mentally deficient (feebleminded)	from 5,300	to 12,300	
For these three classes	from 23,700	to 48,400	or 53,400

Institutional facilities should also be provided for certain classes for which no special provision is now made, as follows:

For mentally deficient offenders	1,300 beds
For psychopathic offenders	1,000 beds
For mentally ill or disturbed children	150 beds

The larger part of the ten-year program should be provided for under appropriations to be made by the General Assembly of 1945, in order to meet **immediate, urgent** needs. This **immediate** building program calls for 18,250 additional bed facilities, as follows:

For the mentally ill:	
At existing institutions	5,000
One new hospital (in northeastern Ohio)	3,500
For the epileptic:	
At Ohio Hospital for Epileptics, Gallipolis	600
At Tiffin (adaptation of existing plant leased with option to buy)	600
For the mentally deficient (feebleminded):	
At Apple Creek Institution	2,800
At Orient Institution	700
New institution on purchased site at Lebanon	3,500
For mentally deficient offenders:	
At Lima, using present hospital plant for this class (present capacity 1,100)	200
For criminal insane and psychopathic offenders:	
A new dual-use institution, with separate departments for these two classes	1,200
For mentally ill or disturbed children:	
At Bureau of Juvenile Research on grounds of Columbus State Hospital	150

The total cost of land, buildings and equipment for this immediate building program is estimated at approximately $36,700,000. The greater part of the appropriation of some $7,000,000 made in 1943 for construction and rehabilitation of mental institutions remains unused due to restriction on labor and building materials, and will be available for re-appropriation. A new additional appropriation of about $30,000,000 will therefore be needed. While of course it is not expected that all of this building can be completed within the next two years, it is highly desirable that the appropriation be made in order that the funds may be assured for that purpose.

PERSONNEL

The proposed program of institutional expansion will mean expenditure not only for bricks and mortar, but for operation and maintenance of institutions having, in total, more patients and more employees. The effectiveness of mental institutions, for the purposes for which they are created, is determined and limited by the number, character, training and efficiency of the medical staff, supervisors, nurses, attendants, social workers and other personnel.

A broadly conceived personnel program for the mental institutions of Ohio, designed to attract and hold a staff adequate in numbers and qualifications, should be aggressively developed. Elements of such a program include:

a. Salary and wage scales that will equal the compensation levels of individuals with comparable duties in similar types of public and private employment. Improvement has recently been made in this respect; but in general, salaries and wages of officers and employees remain inadequate.

b. Working and living conditions that will make jobs more attractive and satisfactory for all classes of personnel; such as, suitable social and recreational opportunities, proper housing for personnel and, in the case of attendants, shorter hours as soon as feasible.

c. A system of in-service training for attendants and others, associated with promotional rewards and the recognition of professional, or at least semi-professional status, for all workers dealing with mental patients, so that they may

have a sense of real participation in the psychiatric care and treatment of their charges.

While immediate steps can and should be taken to raise personnel standards as to numbers of employees, training requirements, etc., a fully developed program must be based on scientific analysis and classification of positions in mental institutions.

EXTRA-MURAL CARE

Development of forms of care and supervision outside of institutions is an important phase of a state mental hygiene program. This refers, in part, to the possibility of greater and earlier use of trial visit, thus conducing to earlier discharge. It refers also to the utilization of "family care", that is, the boarding-out of carefully selected patients in carefully selected homes, for the mentally ill and the mentally deficient, and to the use of colonies, hostels, and sheltered workshops for the mentally deficient. Such measures are largely dependent on a sufficient number of qualified social workers.

A statewide, comprehensive system of outpatient and clinic services of various types, including traveling clinics, is an imperative need. Such a system, administered by the Division of Mental Diseases (the name of which should be changed to Division of Mental Hygiene), would serve both children and adults, and render aid to the mentally ill, the mentally deficient, the neurotic and socially maladjusted, and children with personality difficulties and behavior problems. The clinics would perform both diagnostic and treatment functions, thus helping to effect early detection of mental deviations and prompt hospitalization if indicated, but often making hospital care unnecessary.

Such outpatient and clinic services, resulting from expansion of existing facilities, should be available to schools, courts and social agencies, as well as to the general community, where local facilities are lacking or inadequate. The system should be integrated with local facilities already or in future established, the aim being not only the avoidance of duplication of services but the maximum of coverage of needs throughout the state, by state or community-sponsored clinics, including the state traveling clinics.

RESEARCH

A continuous, coordinated program of research should be conducted under the direction of the Bureau of Prevention and Education, proposed as successor to the present Bureau of Mental Hygiene in the Division of Mental Diseases (Mental Hygiene). This Bureau, in collaboration with the individual mental institutions of the state, would study the causes of mental illness, mental deficiency and other forms of mental deviation, and the results of methods of care and treatment. Such research would be as truly valuable, and in the long run as economical, for the state, as industrial and business research for private corporations.

PREVENTION AND EDUCATION

Informational activities, broadly planned, should be carried on by the Division of Mental Diseases (Mental Hygiene), largely through its Bureau of Prevention and Education, with respect both to the nature of mental illness and other forms of mental affliction, and to the functions and services of institutions and clinics. Knowledge of mental hygiene and of mental hygiene facilities would be promoted through newspapers, radio, pamphlets, lectures, etc., and through cooperation with schools, colleges, civic and social organizations, and industrial and business concerns, with the aim not only of widely disseminating this knowledge but of increasing its application and use. The proposed comprehensive statewide clinic system is, of course, part of the program of prevention and education.

MENTALLY ABNORMAL OFFENDERS

Statutory recognition should be given to two classes of persons, namely, the mentally deficient offenders and the psychopathic offenders, including sex offenders, for whom special provision should be made for prolonged or permanent care and custody, as psychiatric cases.

This calls for revision of the so-called Ascherman Act in order specifically to cover those two classes, and for legislation to provide for their indefinite commitment to the Department of Public Welfare, to facilitate the transfer of such persons from penal, reformatory, correctional and mental institutions to special institutions, and to assure that they shall not be prematurely released into the community.

ADMINISTRATIVE RECOMMENDATIONS

Administrative recommendations of the committee include:

1. Further development of the facilities and services of the Bureau of Juvenile Research, which should become a part of the Division of Mental Diseases (Mental Hygiene).
2. Establishment of a Bureau of Examination and Classification, in the Division of Correction, to make psychological, psychiatric and sociological study of inmates committed to or confined in penal, reformatory or correctional institutions.
3. Creation of the position of business manager in each of the mental institutions of the state, to serve under the superintendent and relieve him of such administrative detail as will enable him to devote his time more fully to psychiatric duties.
4. Removal of the administrative restriction on admission of children under six years of age to institutions for the mentally deficient (feebleminded), as soon as special facilities for the

care and treatment of such children can be provided.

5. Special study by the Division of Mental Diseases (Mental Hygiene) of the problem of aged and infirm patients in state hospitals not requiring continued confinement in mental hospitals, and of the possibilities of other types of provision for such persons, perhaps in connection with programs for the chronically ill.

LEGISLATIVE RECOMMENDATIONS

Included among the committee's legislative recommendations are the following:

1. Change the names of the "institutions for feebleminded" to Apple Creek State School, Columbus State School, and Orient State School, calling the proposed new institution the Lebanon State School.

2. Amendment of Section 1890-97 of the General Code, defining a "feebleminded" person, by substituting the term "mentally deficient" for "mentally defective", and eliminating the classification into idiots, imbeciles and morons.

3. Provision for a central registry of feebleminded (mentally deficient) persons who have been determined to be such by courts or by the schools.

4. Inclusion in the definition of "mental illness" in Section 1890-19 of cases in which the lack of "self-control, judgment and discretion" is caused by excessive addiction to narcotics, sedatives or stimulants.

5. Statutory provision for a hospital for children afflicted with mental illness or serious neurotic or psychoneurotic difficulties.

6. Establishment of a system of state aid to public schools for establishment and operation of special classes for mentally handicapped or slow-learning children, under the supervision of the State Department of Education, and in accordance with rules, regulations and standards set up by the Department.

Do You Know - - -

Dr. Henry M. Goodyear, Cincinnati, was one of the guest speakers at the Refresher Course of the South Carolina Society of Opthalmology and Otolaryngology, Oct. 31-Nov. 2, in conjunction with Founders Day of the Medical College of the State of South Carolina, Charleston, S. C. His subjects were: "Otology: Some Practical Points in Diagnosis and Treatment", and "Nasal Sinus Conditions: Some Practical Points in Diagnosis and Treatment".

* * *

The total enrollment on October 1, 1944, for Blue Cross plans in the United States, for the 11-year period, 1933 to 1944, shows an increase from 10,000 in 1933 to 15,387,496 in 1944. The total for Ohio was 1,986,879, representing 29.1 per cent of the population. Approximately one person in eight—11.6 per cent—of the civilian population of the United States is a member of Blue Cross plans.

* * *

Dr. Jonathan Forman, Columbus, gave two addresses during the 44th Annual Convention of the Central Association of Science and Mathematic Teachers, Inc., Nov. 24-25, at Chicago. He spoke on "A Postwar Program in Conservation", at a meeting of the Biology Section and on "The Wise Use of Natural Resources and the Health of our People" before the Conservation Group.

* * *

Dr. Edgar P. McNamee, Cleveland, President-Elect of the Ohio State Medical Association, was recently elected a director of The Radiological Society of North America.

* * *

The National Safety Council reports that the death toll from falls, the largest single cause of accidental casualties in 1943, numbered 27,400. For the first time in 20 years, deaths from traffic accidents dropped to second place, with a total of 23,400. Deaths from burns numbered 10,350—third place.

* * *

Safety Engineer DeWitt Huffman, Columbus, of the staff of the State Division of Safety and Hygiene, who specialized in dust control in industry, has been commissioned a First Lieutenant in the Sanitary Corps of the Army. He is at Carlisle Barracks, Pa., taking a special course in industrial hygiene.

* * *

The article, prepared by the Committee on Industrial Health of the Ohio State Medical Association, entitled "Providing Industrial Nurses With Written Standing Orders Is a Vital Responsibility of the Physicians", which appeared in the August, 1944, issue of *The Ohio State Medical Journal*, was reprinted in full in the October, 1944, issue of the *Ohio Nurses Review*, official publication of the Ohio State Nurses' Association.

* * *

Organization of all cancer activities on a national scale was advocated by Dr. R. R. Spencer, chief of the National Cancer Research Institute, Bethesda, Md., in a speech at New York, October 31, accepting the Clement Cleveland Award for outstanding service during 1944 in the effort to control cancer by education. The award is made annually by the American Cancer Society. Dr. Spencer received the gold medal of the American Medical Association in 1930 for his discovery of a preventive vaccine against Rocky Mountain Spotted Fever.

Health and Human Resources in Rural Ohio

A. R. MANGUS, COLUMBUS, OHIO
Department of Rural Economics and Rural Sociology, Ohio State University

Installment No. 4

(Continued from November, 1944, issue)

THE preceding sections of this report have been concerned largely with factors which indicate health needs in Ohio. The present section is concerned mainly with the distribution of health resources in the form of professional personnel and facilities.

From various studies it appears that health needs are greatest among socially and economically disadvantaged people and within the poorer geographical areas. At the same time, as is well known, health services and resources tend to be distributed according to effective demand for them rather than according to actual needs. Demand depends upon the ability to pay for medical care and upon widespread understanding of the nature and needs for health care and medical services.

Levels of living characteristic of rural people in Ohio differ very widely in different parts of the state. Health needs and resources are closely related to economic and social conditions. It is the purpose of this section to describe that relationship.

Level-of-living areas. To serve the purpose of this and other studies, a composite index of county levels of living has been constructed from information available from the 1940 census of the rural-farm population. This index is based on nine variable measures. Each separate measure was expressed as a percentage of its state average and all were combined into a composite index for each county. The nine variables are shown in **Table 7.**

The county indexes ranged in value from 32 per cent of the state average in Pike County to 193 per cent in Cuyahoga County. Although no rural-nonfarm measures entered directly into these indexes, rural-farm and rural-nonfarm levels of living are so closely related that the composite as constructed can be taken as a rural level-of-living index.

On the basis of variability in the composite county level-of-living index, Ohio was divided into four areas. For convenience these areas were designated:

Urban-industrial area
Western-agricultural area
Transitional area
Southeastern area

EDITOR'S NOTE: In this installment of his intensely interesting and important study of the health and human resources of rural Ohio, Mr. Mangus discusses "Distribution of Health Resources in Ohio". This series of articles should be "must" reading by Ohio physicians. Previous installments appeared in the September, October and November issues of The Journal. It is hoped that all readers have saved those issues or have clipped the articles for their reference files.

The urban-industrial area, with the highest level-of-living index, includes that part of rural Ohio adjacent to the large industrial centers and subject to metropolitan influences. Included are all of northeastern Ohio, the areas adjacent to Cincinnati and Dayton, and Franklin County, in which is located the city of Columbus. Western and central Ohio, except the urbanized sections around Columbus, Dayton, and Cincinnati, are included in the western-agricultural area. In this area the level-of-living index is 106, compared with 135 in the urban-industrial area. The southeastern Ohio area consists of those counties having the lowest level-of-living indexes; included is the area lying north and west of the Ohio River from Adams to Belmont Counties, which comprises much of the most hilly section of the state. In level of living, the counties designated "transitional" are intermediate between the southeastern area and the areas to the north.

These four areas are clearly differentiated not only on the basis of the composite level-of-living index, but also by the several items entering into that index **(Table 7).**

Population distribution in level-of-living areas. The urban population of Ohio is heavily concentrated in the urban-industrial area as defined above. In 1940 a little more than 78 per cent of all Ohio residents in places of 2,500 or more inhabitants were located in that highly urbanized area, while only 25.7 per cent of the farm population and 43.7 per cent of the rural-nonfarm was found there.

Table 7. Level-of-Living Factors in Subareas of Ohio, 1940 (median county)

Factor	All areas	Urban-industrial area	Western-agricultural area	Transitional area	Southeastern area
Per cent of farms having—					
Automobiles	80.8	84.0	91.0	76.0	62.0
Telephones	38.0	37.0	44.0	28.5	28.0
Electric power line adjacent	73.1	90.0	85.0	63.5	28.0
Hard-surfaced road adjacent	42.4	63.0	44.0	26.0	18.0
Electrified dwelling	61.4	82.5	69.0	48.0	20.0
Per cent of rural-farm dwellings having—					
Running water	23.1	38.0	20.0	19.0	7.5
Private bath	15.8	27.0	14.0	11.0	4.0
Indoor toilet	17.2	29.0	15.0	12.5	5.0
Per cent of rural-farm automobiles—					
1936 or later models	43.8	48.5	46.0	40.0	33.0
Composite level-of-living index	100.0	135.0	106.0	80.0	50.0

Source: Mangus, A. R., McNamara, R. L. *Levels of Living and Population Movements in Rural Areas of Ohio, 1930-1940*, O.A.E.S., Bulletin 639, March, 1943, p. 6.

The proportion which rural people comprised of the total population of each area in 1940 was highest in the poorer areas. Rural residents constituted only 18.3 per cent of the population in the urban-industrial area, but their proportion rose to 69 per cent of the total population of southeastern Ohio. While farm people comprised only 6.2 per cent of the population in the urban-industrial area, they made up one-third of the population of the western-agricultural area, one-fourth of the population of the transitional area, and 36.8 per cent of the population in the southeastern area (Table 8).

Table 8. Distribution of Population within Level-of-Living Areas, Ohio, 1940

Area	Total population	Urban population	Rural population		
			Total	Nonfarm	Farm
All Areas	100.0	66.8	33.2	17.7	15.5
Urban-industrial	100.0	81.7	18.3	12.1	6.2
Western-agricultural	100.0	42.8	57.2	23.7	33.5
Transitional	100.0	41.4	58.6	32.7	25.9
Southeastern	100.0	30.8	69.2	32.4	36.8

Source: *Sixteenth Census of United States, 1940.*

Birth and death rates. Birth and death rates furnish important indications of health conditions and health needs in different areas. Those areas having high birth rates need more health services, including specialized services for mothers and children, than do those areas where birth rates are low. Child-bearing is hazardous to mothers who lack adequate medical supervision. Infants and children deprived of adequate medical care have lessened chances for survival and increased chances of suffering impairments which may handicap them throughout their lives. Differential death rates among infants and among other comparable age groups in different areas indicate differences in health conditions which usually include inequalities of access to medical care and other health services.

The birth rate may be expressed as the number of infants born during a given year per 1,000 women of child-bearing age, that is, 15-44 years old. In 1940 the number of births per 1,000 women was higher on farms and in small towns than in urban places. This was true in every one of the level-of-living areas of Ohio. The greatest rural-urban difference was found in the southeastern area where there was 53 per cent more births per 1,000 women in the rural places than in cities of 10,000 or more population (Table 9).

The rural birth rate per 1,000 women of child-bearing age was lowest in the urban-industrial area where it stood at 67.6 in 1940. The rural birth rate was about 23 per cent higher in the western agricultural and in the transitional area, and was around 35 per cent higher in the southeastern area where 91.2 births were reported for each 1,000 rural women.

The infant death rate, a sensitive measure of health conditions, was in every area higher among those babies born to rural and small town mothers than among those born to city parents. Even more striking, however, was the wide area differences in infant death rates both rural and urban. In the most prosperous rural area (urban-industrial) 39 babies died under 1 year of age for each 1,000 infants born alive to rural and town mothers in 1940. The infant death rate among rural and town babies rose to 43 in the western-agricultural area, to 49 in the transitional area, and to a peak of 62 in the southeastern area. In other words, the area with the highest infant death rate had 58.4 per cent more deaths per 1,000 births than did the area with the lowest infant death rate (Table 9).

It is highly significant that those areas where birth rates and infant death rates were highest were the areas where the fewest births occurred in hospitals. In the urban-industrial area where the infant death rate was lowest, 63.6 per cent of all births to rural mothers occurred in hospitals,

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Table 9. Resident Birth, Death and Infant Death Rates and Per Cent of Births in Hospitals by Urban and Rural[1] Residence and Level-of-Living Area, Ohio, 1940

Area	Births per 1,000 females 15-44 yrs. old		Deaths per 1,000 population		Deaths under 1 yr. per 1,000 live births		Per cent of births in hospitals	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
All Areas	63.2	78.2	11.2	11.7	38.0	45.7	79.0	40.8
Urban-industrial	61.7	67.6	11.0	10.9	36.6	39.4	82.0	63.6
Western-agricultural	74.8	83.4	12.4	12.5	40.7	43.4	66.2	36.1
Transitional	72.1	83.9	11.8	11.6	46.4	49.3	60.1	26.8
Southeastern	59.6	91.2	12.3	12.2	60.1	62.4	67.2	14.3

Source: Population—*Sixteenth Census of the United States, 1940.*
Vital Statistics—*Linder and Grove, Vital Statistics Rates in the United States, 1900-1940,* U.S. Govt. Printing Office, 1943.
[1]Including small towns under 10,000 population.

but in the southeastern area where the infant death rate was highest only 14.3 per cent of all rural babies were born in hospitals in 1940 (Table 9).

Distribution of physicians. The American Medical Directory for 1942 listed a total of 8,864 physicians in active practice at the beginning of that year. This number represented the medical manpower of the state as it existed at the beginning of the War. At that time there was one doctor for each 779 people in Ohio. These physicians were, however, very unevenly distributed among the level-of-living areas. Physicians were concentrated in the urban-industrial area and in the large urban centers of that area. In the urban-industrial area as a whole there was one doctor for each 674 people. This population-doctor ratio rose to 955 in the western-agricultural area, 1,245 in the transitional area, and 1,334 in the southeastern area. Relative to population there were then before the War about twice as many physicians in the area where the level of living was highest as there were in the area where the level of living was lowest.

The uneven distribution of medical manpower was even more striking than is indicated by the above figures, for the proportion of aged and less effective doctors was highest for the most disadvantaged areas. In the urban-industrial area, for example, only 13 per cent of the physicians were 65 years old and over. The proportion that these aged physicians comprised of the total rose to 28.8 per cent in the western-agricultural area and approached one-fourth in the other two areas. The number of persons per doctor under 65 years of age was 2.3 times greater in southeastern Ohio than in the urban-industrial area (Table 10).

Table 10. Distribution of Physicians in Ohio by Level-of-Living Areas, 1942

Area	Population per physician 1942			Per cent of physicians 65 yrs. old and over	Physicians in armed forces per 100 under 65 yrs. in 1942
	All physicians	Physicians less than 65 yrs. old	Members of specialists' societies		
All Areas	779	937	4,962	16.6	34.4
Urban-industrial	674	774	3,630	13.0	34.4
Western-agricultural	955	1,342	11,648	28.8	37.4
Transitional	1,245	1,622	17,758	23.2	32.0
Southeastern	1,334	1,775	24,010	24.9	27.6

Source: *American Medical Directories,* 1940 and 1942. Physicians in the armed forces, reported by *The Ohio State Medical Journal.*

Table 11. Population Per Effective Physician

Area	Effective physicians	Population per effective physician
All areas	7,514	919
Urban-industrial area	5,712	775
Western-agricultural area	1,093	1,236
Transitional area	437	1,544
Southeastern area	272	1,677

In establishing a basis for distributing physicians between the armed forces and civilian practice, the Procurement and Assignment Service of the War Manpower Commission has considered those practitioners 65 years old and over as on the average only one-third effective. If the Procurement and Assignment Service method of computation is followed, then the 8,864 practitioners in Ohio prior to the War formed the equivalent of only 7,514 fully effective doctors. On the same basis, the population per effective physician in the several areas in 1942 was as shown in Table 11.

The number of fully effective physicians that would be required to meet the medical needs of a typical population has not been fully determined. The Committee on the Costs of Medical Care arrived at the conclusion that in order to meet the actual need for individual preventive services, maternity services, and diagnosis and

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*More detailed information, based on published reports, will be sent promptly on request.

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treatment of diseases and defects, one physician is needed for each 742 people.[21] The Procurement and Assignment Service has set the population-doctor ratio at one effective physician for each 1,500 people as a maximum above which the public health might be jeopardized. As is seen in the preceding table in both the transitional area and in the southeastern area, that maximum was exceeded even before the induction of large numbers of younger doctors into the armed forces.

Since Pearl Harbor a little more than one-third of all physicians under 65 years old who were in practice in Ohio at the beginning of the War have entered the armed forces or other governmental service. The proportion of physicians thus withdrawn from practice varied from nearly 28 per cent in southeastern Ohio to 37.4 per cent in the western-agricultural area (Table 10).

The Medical Directory of 1940 listed 1,392 physicians who were specialists and who were members of specialists' societies, such as the American College of Surgeons. This number comprised 15.8 per cent of all active physicians, and amounted to one specialist for each 4,962 people in the state. The vast majority of specialists were, however, located in the larger urban centers. In the urban-industrial area there was one specialist for each 3,630 people. There were three times the number of persons per specialist in the western-agricultural area, and the population-specialist ratio rose to 24,000 people for each specialist in southeastern Ohio. Outside the urban-industrial area and outside the larger urban centers of the other areas, there were practically no pediatricians, internists, heart specialists, psychiatrists, or other specialized physicians (Table 10).

Distribution of dentists. The Directory of Registered Dentists issued by the Ohio State Dental Board in 1942 listed 3,813 practicing dentists in the state. Of these 76 per cent were located in the urban-industrial area where there was one dentist for each 1,527 people. The population-dentist ratio increased in each of the poorer areas and rose to 3,258 persons per dentist in southeastern Ohio. As in the case of physicians, dentists in the more rural areas are older on the average than those in the large cities. For example, more than 41 per cent of all dentists in the western-agricultural area and in the southeastern area had graduated from dental school in 1912 or earlier. Most of these practitioners must have been at least 55 years of age in 1942. One-third of those in the transitional area completed dental school before 1913, but only 24.1 per cent of those practicing in the urban-industrial area had graduated so long ago (Table 12).

There is an enormous discrepancy between the supply of dentists in 1942 and the numbers that would be required to meet the existing dental needs of a typical population group. On the assumption that existing dental needs would be cared for, the Committee on the Costs of Medical Care estimated that the services of between 99 and 179 dentists per 100,000 population would be required, the actual requirement depending upon the extent to which dental hygienists, X-ray specialists, and other technicians are used to supplement the work of the general dental practitioner.

Even if only 99 dental practitioners per 100,000 population were taken as a standard, one dentist would be required for each 1,010 people. In no area of Ohio was that standard met in 1942. The most favored level-of-living area had 50 per cent more population per dentist, and in the southeastern area the population-dentist ratio was more than three times the minimum arrived at by the Committee on the Costs of Medical Care.

On the assumption that dentists do all their own laboratory work, X-ray work, and scaling and cleansing, the committee estimated the need at 179 practitioners per 100,000 population which would be one dentist for each 560 people. In the most favored area of Ohio there was in 1942 only one dentist for each 1,527 people. In the least favored area there was only one dentist for each 3,258 people (Table 12).

Distribution of general hospital beds. In 1942 there were in Ohio 201 hospitals of all types which met the standards for registration by the Council on Medical Education and Hospitals of the American Medical Association. These hospitals contained 50,211 beds and admitted 568,596 patients during the year 1942. Of the 50,211 beds, 22,382, or 44.6 per cent, were in 16 mental

Table 12. Distribution of Dentists by Level-of-Living Areas, Ohio, 1942

Area	Population per dentist		Per cent who graduated 1912 and earlier
	All dentists	Dentists graduating in 1913 or later	
All areas	1,812	2,507	27.6
Urban-industrial	1,527	2,012	24.1
Western-agricultural	2,526	4,303	41.3
Transitional	2,812	4,217	33.3
Southeastern	3,258	5,632	42.1

Source: *Directory of Registered Dentists*, 1942, issued by the Ohio State Dental Board.



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and nervous disease hospitals; 21,107, or 42.0 per cent, were in 151 general hospitals; the remaining beds were in tuberculosis hospitals and other institutions. Of the general hospitals in Ohio 145 were serving the general public, while six were operated by the Federal Government for military personnel and for veterans. A total of 76 of the general hospitals were operated by non-profit associations, and these hospitals contained more than one-third of all hospital beds in Ohio. In addition 36 general hospitals with 6,801 beds were operated under the auspices of religious denominations, and 25 with 4,499 beds were operated by state and local government units. A total of eight small general hospitals which together had only 236 beds were operated as proprietary institutions (Table 13).

The Committee on the Costs of Medical Care estimated that about 462 general hospital beds would be required to adequately serve a typical unit of 100,000 people. On the basis of that standard no large area in Ohio has an adequate number of general hospital beds. The urban-industrial area had about three-fourths as many beds as would be required to meet the standard. The western-agricultural area and the transitional area each had only about one-third enough beds, while the southeastern area had less than one-fourth as many registered general hospital beds as would be required to meet the standard of 462 beds per 100,000 people.

In addition to the registered general hospitals discussed above, there were in Ohio in 1942 a total of 27 small general hospitals that failed to meet standards for registration by the A.M.A. due to inadequate facilities, unapproved practices, or other reasons. These unregistered general hospitals contained only 664 beds. The number of registered general hospitals that might be considered sub-standard from other points of view is unknown. It is known, however, that many small rural hospitals are not much more than boarding houses for sick people, or workshops for doctors. Of the 145 registered general hospitals serving the general public in 1942, only 77 were approved by the American College of Surgeons as meeting unconditionally its mini-

Table 13. Hospital Facilities in Ohio by Type of Service and by Type of Ownership or Control, 1942[1]
(All hospitals registered by the American Medical Association)

Type of hospital and control	Hospital	Beds	Bassinets	Patients admitted	Average census	Per cent of beds occupied
All hospitals	201	50,211	3,214	568,596	43,595	86.8
General hospitals	151	21,107	3,096	538,006	16,033	76.0
Nonprofit association	76	7,739	1,416	238,520	5,869	75.8
Church	36	6,801	1,179	201,722	5,405	79.5
Governmental	31	6,331	456	92,677	4,649	73.4
Federal	6	1,832	3	14,544	1,498	81.8
State	2	430	35	8,845	293	68.1
County	6	540	86	11,422	345	63.9
City	17	3,529	332	57,866	2,513	71.2
Proprietary	8	236	45	5,087	110	46.6
Mental and nervous hospital	16	22,382	...	7,224	21,748	97.2
State	9	20,471	...	4,441	19,928	97.3
Federal	1	1,522	...	463	1,538	101.1
Proprietary	5	314	...	1,504	235	74.8
Nonprofit association	1	75	...	816	47	62.7
Tuberculosis hospital	21	3,420	...	3,513	2,889	84.5
Governmental	18	3,089	...	3,125	2,631	85.2
Nonprofit association	1	105	...	72	65	61.9
Proprietary	2	226	...	316	193	85.4
Epileptic (State)	1	2,170	...	186	2,062	95.0
All others[2]	12	1,132	118	19,667	863	76.2

Source: *The Journal of the American Medical Association*, Vol. 121, No. 13, March 27, 1943.

[1]Does not include related institutions, i.e., infirmaries, nursing homes, institutions for feebleminded, and other institutions not giving a full hospital service.

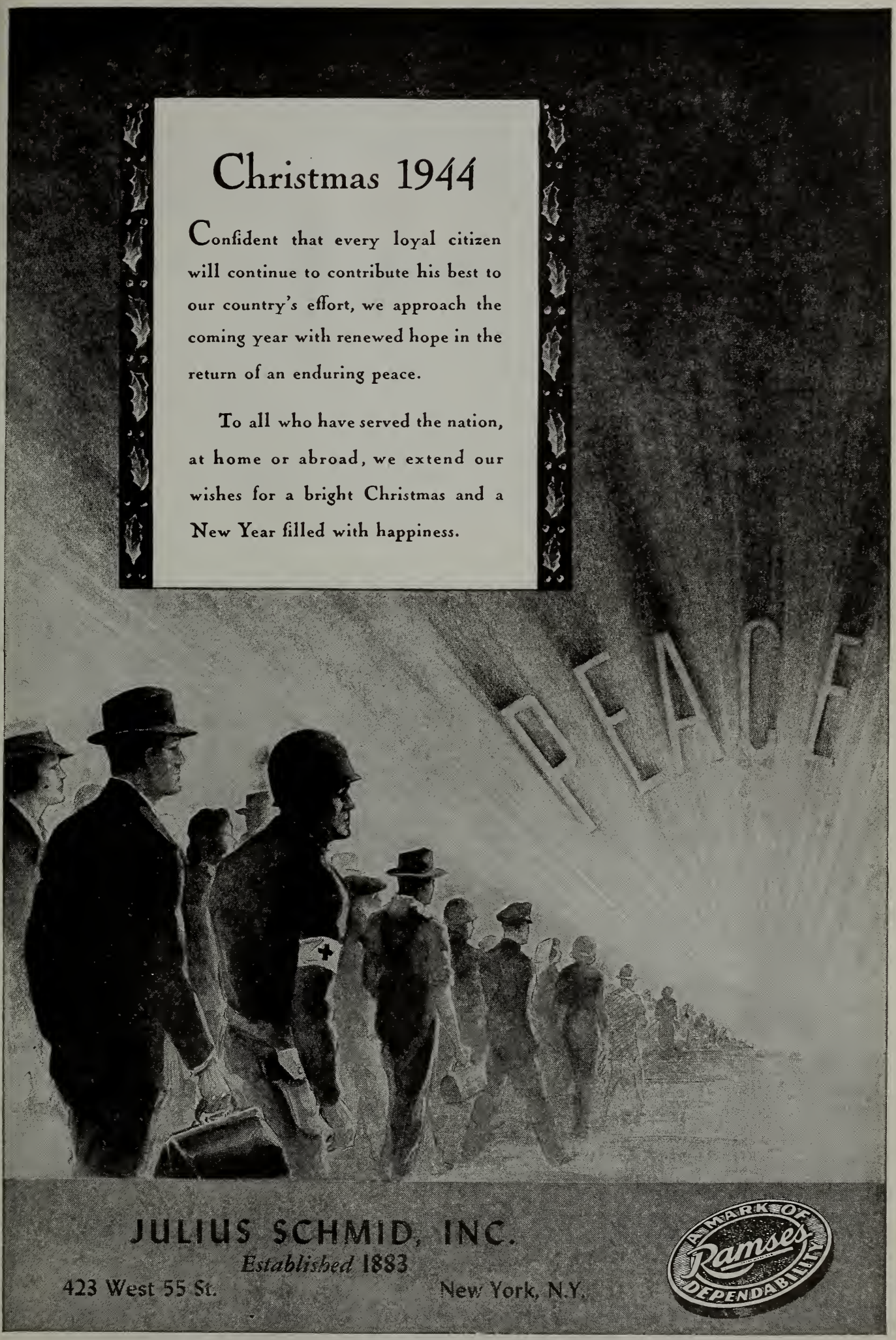
[2]Includes children's, maternity, and institutional hospitals.

The registered general service hospitals serving the general public in Ohio in 1942 numbered 145 and contained 19,275 beds. These registered general hospitals provided 278 beds per 100,000 population for the state as a whole. It is notable, however, that these general hospital beds showed even greater concentration in the large urban centers than did physicians and dentists. The urban-industrial area is best supplied with 354 beds per 100,000 population. No other area had even half that many. In the southeastern area there were only 113 beds per 100,000 population (Table 14).

Table 14. Distribution of Registered General Hospital Beds by Level-of-Living Areas, Ohio, 1942

Area	Beds per 100,000 population	Per cent of hospital beds occupied
All areas	278	75.6
Urban-industrial	354	76.7
Western-agricultural	149	70.5
Transitional	158	74.6
Southeastern	113	60.3

Source: *The Journal of the American Medical Association.* Hospital number. Vol. 121, No. 13, March, 1943.


Christmas 1944
Confident that every loyal citizen will continue to contribute his best to our country's effort, we approach the coming year with renewed hope in the return of an enduring peace.
To all who have served the nation, at home or abroad, we extend our wishes for a bright Christmas and a New Year filled with happiness.
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mum standards. For the most part these were the large urban hospitals, and they contained 84.2 per cent of all general hospital beds.

Distribution of public health expenditures. Maintenance of fully adequate public health work for the meeting of all preventive needs would probably require an expenditure of about $2 per capita. A study by the Ohio Social Planning Committee found that in 1938 the average expenditure of all Ohio health departments, rural and urban, amounted to only 41 cents per capita. City health departments were in general somewhat better financed than were the county health departments which serve rural areas. Public health expenditures for rural departments amounted to only 18 cents per capita in the transitional area, 27 cents per capita in the southeastern area, and 36 cents per capita in the rest of the state.[22]

Other health personnel. Other health personnel in Ohio includes private and institutional nurses, pharmacists, subsidiary practitioners performing limited service in the field of medical care, such as, chiropodists and optometrists, and sectarian practitioners, including osteopaths, chiropractors, and faith healers.

The 1940 census enumerated 18,414 nurses, 3,731 pharmacists, 504 chiropractors, 672 optometrists, and 947 healers and other medical service workers. In 1942 there were 509 osteopaths in practice throughout Ohio.

REFERENCES

21. Lee, Roger I., and Jones, L. W., *Fundamentals of Good Medical Care*, p. 115.

22. Ohio Social Planning Committee, *Social Data in Ohio*, 1938. Columbus, Ohio, April, 1941, pp. 144-169.

(To be continued)

Physicians Address Welfare Conference

Physicians appearing on the program for the Fifty-Fourth Annual Ohio Welfare Conference, Nov. 26-29, at the Deshler-Wallick Hotel, Columbus, included the following: Dr. W. W. Bauer, Chicago, Director of Health Education, American Medical Association; Dr. Frank F. Tallman, Columbus, State Commissioner of Mental Diseases; Dr. Earl Baxter, Columbus, professor of pediatrics, Ohio State University College of Medicine; Dr. Bruno Gebhard, director, Cleveland Health Museum; Dr. Henry C. Schumacher, director, Cleveland Guidance Center; Dr. Carl Wilzbach, health commissioner of Cincinnati; Dr. C. A. Neal, Cincinnati, superintendent, Hamilton County Home; Dr. Marion Gibbons, Cleveland; Dr. W. D. Bishop, Greenville, Darke County health commissioner and secretary-treasurer of the Ohio Federation of Public Health Officials; Dr. Roger Heering, Columbus, venereal disease control officer, State Department of Health.

New Export Outlet Firm Formed By General Electric X-Ray

President John H. Clough of the General Electric X-Ray Corporation, Chicago, has announced the formation, by that company and the International General Electric Company, of a new firm, known as the General Electric Medical Products Company, which will serve as the export outlet for General Electric X-Ray and thirty-five surgical equipment manufacturers in the United States.

The new company replaces and extends the activities of the Export Department of General Electric X-Ray Corporation which normally operated in more than sixty counties through various affiliates, distributors and subsidiaries.

The General Electric Medical Products Company will operate only in export territories. It has been granted exclusive rights for world-wide distribution outside of the United States and Canada of surgical equipment products manufactured by a number of firms, which include:

American Sterilizer Company, Erie, Pennsylvania; Rudolph Beaver, Inc., Waltham, Massachusetts; Brandenberg Instrument Company, New York; Crescent Surgical Sales Company, Inc., New York; Victoreen Instrument Company, Cleveland, Ohio; DePuy Manufacturing Company, Warsaw, Indiana; Gomco Surgical Manufacturing Corporation, Buffalo, New York; Fred Haslam and Company, Brooklyn, New York; MacAlaster-Bicknell Company, Cambridge, Massachusetts; MacGregor Instrument Company, Needham, Massachusetts; Master Surgical Instrument Corporation, Irvington, New Jersey; McKesson Appliance Company, Toledo, Ohio; E-K Medical Gas Division of Thomas A. Edison, Inc., Bloomfield, New Jersey; Medbridge Supply Company, East Cambridge, Massachusetts; Offner Electronics, Inc., and Salvus Products, Inc., both of Chicago; Specialties Manufacturing Company, Inc., Bloomfield, New Jersey; the United States Catheter and Instrument Corporation, Glenn Falls, New York; and C. R. Bard, Inc., New York.

Elect New Officers

Dr. R. W. DeCrow, Wilmington, health commissioner of Clinton County, is the new president of the Ohio Federation of Public Health Officials. Other officers, elected at the Federation's annual meeting Oct. 25, at Columbus, include: Dr. Walter H. Hartung, Toledo health commissioner, president-elect; Dr. W. D. Bishop, health commissioner of Greenville and Darke County, secretary-treasurer; Dr. J. J. Sutter, health commissioner of Wayne County and Wooster, delegate to the national federation; and Dr. E. R. Shaffer, Akron, Summit County health commissioner, alternate.

Dr. C. C. Sheldon, Port Clinton, who took up flying as a hobby last July, recently passed his final tests for a private pilot's license at the Toledo Airport.

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. . . or for many days to come. His parents didn't realize that classroom congestion frequently helps to spread infections and contagions. They didn't take the precaution of having their little boy immunized by their physician.

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WAR NOTES

From the Public Relations Office of the United States Marine Corps we have an interesting yarn about two Cincinnati Navy medical officers. Written by Sgt. Phil H. Storch, a Marine Corps combat correspondent and formerly of the Allentown, Pa., *Morning Call*, here 'tis:

"Somewhere in the Pacific—(Delayed)—Two Cincinnati physicians who are close friends in civilian life, but who had not seen one another for more than two years, were brought together through unusual circumstances while en route here. The doctors are Navy Lieutenants Daniel V. Jones and Arthur Spreen.

"Lieut. Jones was senior medical officer of the convoy which brought the Marines to this base. In this capacity he was notified of an injury to a man who was on another ship. To get detailed information of the injury, Lieut. Jones radio-phoned the ship carrying the injured man. His request for a medical officer was answered by Dr. Spreen's voice. Lieut. Jones recognized his friend immediately and they made arrangements to get together at the convoy's first port of call. Both doctors are graduates of the University of Cincinnati College of Medicine and both hold membership in the same medical fraternity, Alpha Kappa Kappa. They both practiced pediatrics in civilian life and were on the staff of the Children's Hospital in Cincinnati. They both entered the Navy in the Summer of 1942."

* * *

Approximately one-half of the 1,932 military members of the Ohio State Medical Association are serving overseas, a checkup of The Journal's mailing stencils reveals.

* * *

On the basis of recommendations by medical officers recently repatriated from German prison camps and hospitals, the American Red Cross has sent 5,000 tubes of penicillin by air express to the International Red Cross Committee in Geneva to be used for American prisoners of war held by Germany.

* * *

LST hospital ships lying close inshore proved the answer to one of the Navy's more serious problems—getting surgical attention closer to wounded men on the beach, according to an A. P. dispatch from aboard one of such ships off Leyte. The story mentioned Comdr. Fred A. Smith, Akron, assistant division surgeon for the Fifth Marines.

* * *

Lt. Mel A. Davis, Painesville, V-mails from aboard a ship in the Pacific that the mailman is doing a fine job out there and delivers *The Journal* regularly. At sea for over a year, he has seen quite a number of Ohio Navy medics, including Drs. Ernstene and Engel of the Cleveland Clinic; Drs. G. O. Hedlund and C. B. Elliott, from his home town, Painesville; and Dr. Kenneth Wharram, Springfield.

* * *

"After 21 months in the field with a 'Long Tom' field artillery outfit, with eight months of continuous combat, I sort of enjoy being back on a big general hospital surgical staff", writes Capt. H. T. Pease, Wadsworth. He doesn't give any clues as to his whereabouts, but it sounds like Italy.

* * *

Capt. L. A. Hamilton, Athens, who last wrote to *The Journal* from Corsica, is now a malaria patient in a hospital in Northern Italy.

* * *

An opportunity to do surgery after 46 months in the Army is "very enjoyable", writes Maj. Jas. W. Halfhill, Lima, now at the Regional Hospital, Camp Shelby, Miss. Here's his story: "After a fractured knee while on La. maneuvers in 1941 as C. O. of Co. C, 112th Med. Regt., 37th Div., and a long convalescence at La Garde, I was returned to duty at the C. Surgeon's office here. The knee blew up again, and I spent two months in Foster Gen., and am now on the surgical staff here."

* * *

Lt. Col. Claude S. Perry, Columbus, with a general hospital unit in Belgium, reports that Aachen must have been a beautiful resort town, but as the G. I. said: "The houses are still all there, only we arranged the bricks in them a little differently."

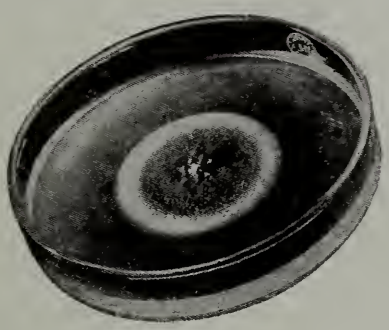
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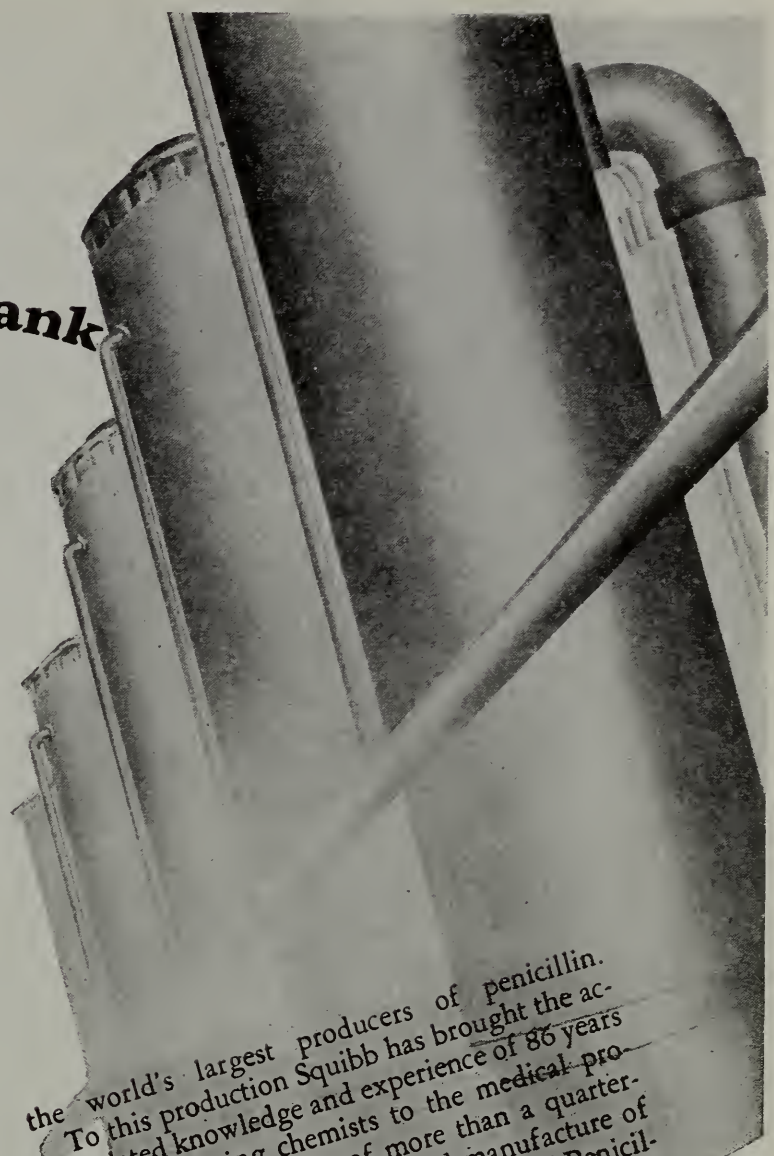
Thanks to Capt. Nathan C. Gordon, Akron, for advising us promptly of his new APO. He V-mailed it from Normandy, where he was camped out in a field with a field hospital, waiting to be sent up to the front.

* * *

New assignments, here and there, within the United States: Capt. Theodore D. Sawyer, Crestline, Hdqrs. Med. Det., XXII Corps, Fort DuPont, Del.; Lt. Thos. R. Shoupe, Findlay, 552 M.H.S.P., Ft. Hamilton, N.Y.; Lt. Ralph Tapper, Findlay, Sta. Hosp., Stout Field, Indianapolis, Ind.; Lt. Comdr. H. H. Wyand, Cleveland, U.S. Naval Hosp., Key West, Fla.; Capt. J. Wertheimer, Painesville, 1543 S.U. Rossford Ord. Depot, Toledo;

From Petri Dish to Giant Tank





THAT, in brief, is the drama of the mushrooming growth of penicillin production. The House of Squibb, as you would expect, has played a major part in this triumph of modern science.

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* * *

Bits of news about Miami County military members: Capt. Howard Farmer, Fletcher, 366 Med. Bn., Camp Rucker, Ala.; Lt. John F. Beachler, Jr., Piqua, with a San Francisco APO, awaiting shipment; Maj. W. W. Trostel, Piqua, Drew Field, Tampa, Fla.; Capt. Emory R. Irvin, Bradford, now in France; Maj. Kenneth F. Lowry, Troy, previously in Italy, was in on the invasion of Southern France; Capt. Paul Foy, Troy, now somewhere in the Pacific; Lt. Col. B. E. Hyde, Troy, attending the Command and General Staff School, Ft. Leavenworth, Kansas; Maj. Hugh Wellmaier, C.O., Sta. Hosp., Camp Breckenridge, Ky.

* * *

Lt. Col. Joseph M. Hayman, Jr., Cleveland, chief of medical service, Moore General Hospital, Swannanoa, N.C., was one of the guest speakers at a meeting of Service Command Consultants in Medicine, Oct. 30-31, at White Sulphur Springs, Va.

* * *

Lt. Edwin A. Riemenschneider, Cleveland, reports that he is doing Ob. and Gyn. on a very active dependents' service at the Naval Hospital, San Diego, Calif.

* * *

In India, as a flight surgeon with the First Air Commando Group, is the rugged assignment of Capt. Merritt K. Marshall, Findlay, who says: "This part of the world is forgotten in the sense of its civilization, although it is probably to be remembered by all for present and future war activities. . . . Really am enjoying my assignment as much as possible when 12,000 miles from home."

* * *

Army member of the Interdepartmental Quarantine Commission, Lt. Col. Phillip T. Knies, Columbus, has been assigned as Army Quarantine Liaison Officer to the Surgeon General, and is stationed in the Epidemiology Division, Preventive Medicine Service, Washington, D.C.

* * *

After a short stay at the U.S. Naval Hospital, San Diego, and training for the Fleet Marine Force at Camp Pendleton, Lt. (j.g.) Charles E. Fralick, Columbus, has arrived at his present station out in the Pacific, with a Field Depot, which is a combat outfit of the Supply Service.

* * *

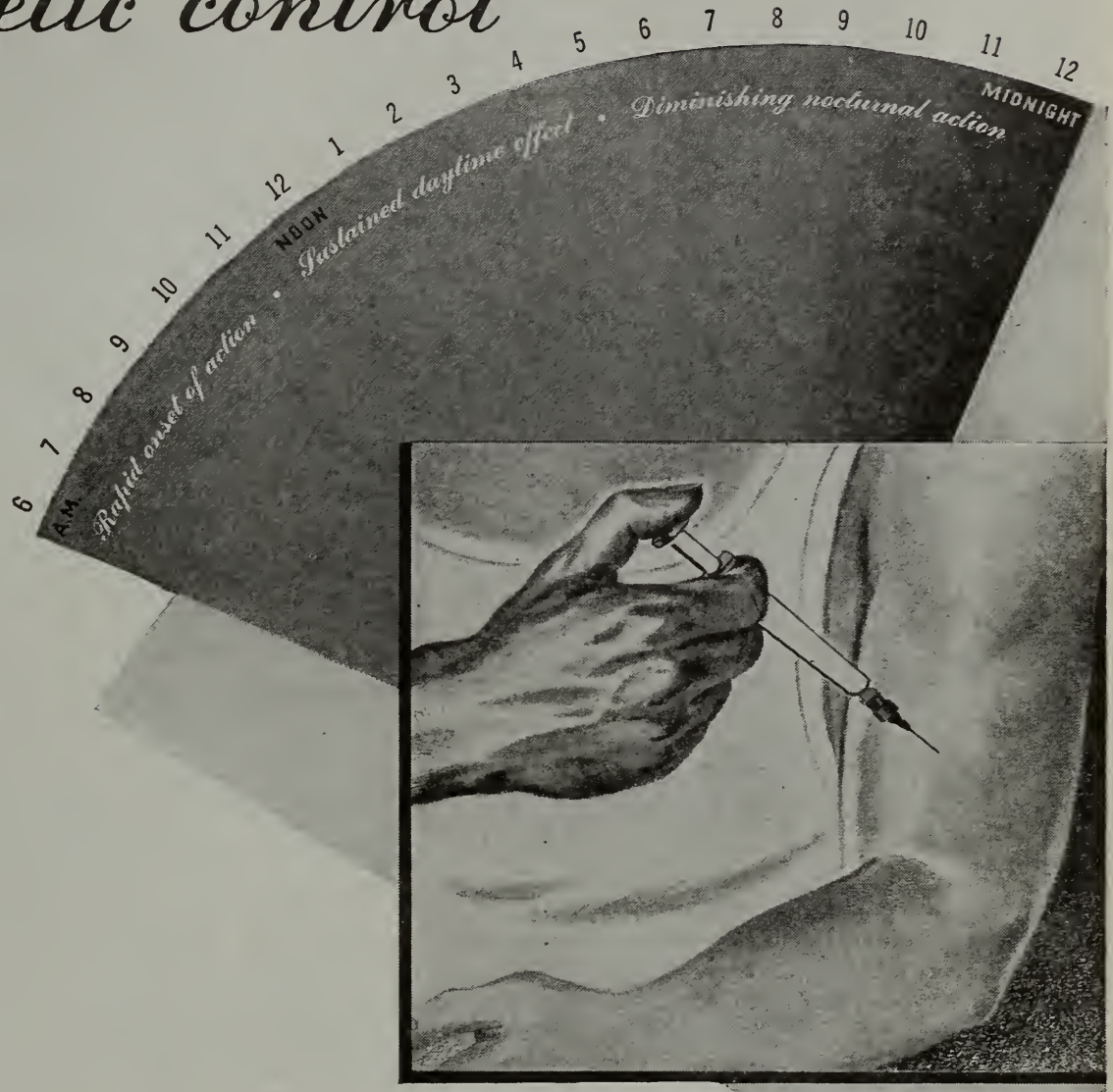
Flash—our first letter from Germany! It comes from Maj. Henry P. Limbacher, Cleveland—and he has really been places! "I have been in the army four years now and in an infantry division for the entire period. I was in the African landings, Tunisian and Sicilian Campaigns, in England, the Cherbourg Peninsula Battles, the break through, and now in Germany. I have had many adventures, some pleasant and some awesome. Just now I am near a forest where deer are grazing within sight of our camp. Deer runs, well kept meadows, blinds to shoot from—a very enjoyable place in peacetime. I received my promotion to major a short time ago and have been awarded a Bronze Star Medal.

Though I have never written, I have been receiving The Journal and have enjoyed reading it, especially the notes of doctors in the service and discussions concerning the present crisis in medical practice. It has been a fine gesture to keep up our membership and to continue to send us The Journal. I really appreciate it. My regards to the Professors at O.S.U. who still remember me."

* * *

According to *The Military Surgeon*, Lt. Col. Eugene J. Stanton, Elyria, is chief surgeon of the Y—Force Operations Staff in Southwest China. Col. Stanton entered Army service in September, 1941. Following service with the Desert Command in California, he was sent to India in January, 1943, and assigned to duty with the X-Force on the Ledo Road, where he set up the first unit in the chain of medical facilities in that area. In May, 1943, he was transferred to China, and assigned to his present unit, which is a large American liaison group engaged in assisting the Chinese to reopen the Burma Road. His duties involve the

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supply of Chinese army hospitals, and the instruction of the personnel manning them.

* * *

From Oahu, Hawaii, where he is on the staff of a field hospital, Capt. Bert Seligman, Toledo, V-mails: "After participating in the Mariannas campaign, being actively occupied in the Saipan and Tinian jobs, am back on Oahu, which was a stop in the right direction toward home, but not far enough. As general surgeon for one of the platoons, I had the opportunity to do a tremendous amount of work of a highly diversified nature. The only similarity between war surgery and every-day civilian surgery that I experienced was the two appendectomies I performed on Saipan. Here's to a speedy and successful conclusion of this stupid mess called war."

* * *

Capt. Oscar L. Coddington, Columbus, with the medical detachment of a field artillery battalion, though in the thick of the fighting in Germany, thoughtfully V-mails a change in his APO. He says: "Have been in active combat with the artillery ever since landing on the continent last June, having come through France, Belgium and am now in Germany. Those of us who are in battalion aid stations at the front lost contact with medicine in general, and are always glad to get the latest information as given in *The Ohio State Medical Journal.*"

* * *

Congratulations to Maj. Edward R. Schumacher, Columbus, now a flight surgeon in England, who has received the Soldier's Medal for rescuing a pilot from a burning plane.

* * *

Capt. William L. Porter, Cincinnati, previously stationed on the Admiralty Islands, is reported to be with the First Cavalry Division which is in that hard fighting at Leyte.

* * *

Comdr. Sherl J. Winter recently visited his home town, Dayton. He is in the pediatric department of the U.S. Naval Hospital, San Diego, where he has been stationed for 31 months.

* * *

A few more new assignments within the United States: Maj. Archie Fine, Cincinnati, AAF Conv. Hosp., Nashville, Tenn.; Lt. Albert G. Boldizar, Cleveland, Valley Forge Gen. Hosp., Phoenixville, Pa.; Lt. Col. James H. Carson, Martins Ferry, 93rd Field Hosp., Camp Ellis, Ill.; Lt. E. B. Bowman, Cincinnati, 24th ASG, ASCTC, Fresno, Calif.; Lt. Col. S. D. McCoy, Columbus, Hq., 11th Med. Tng. Reg., Camp Barkeley, Texas; Capt. Robert Ringer, Cambridge, AAF Conv. Hosp., Ft. Thomas, Ky.; Lt. R. H. Breneman, Akron, 555th Service Group, ASCTC, Fresno, Calif.; Maj. Richard H. Wallace, Columbus, 224th Gen. Hosp., Ft. Lewis, Wash.; Capt. Paul D. Meyer, Cleveland, 3593 Service Unit, Fletcher Gen. Hosp., Cambridge, Ohio.

* * *

The Bronze Star Medal for courageous action at Bougainville, Solomon Islands, has been awarded Capt. Ralph L. I. Phillips, Columbus, a medical officer in the 37th Division.

* * *

Bits of news about Cleveland medical officers, from the *Bulletin of the Cleveland Academy of medicine*: Capt. Garner B. Meads, now in France with an evacuation hospital, got acquainted with Jerry's buzz bombs before leaving England—not too close, but close enough to have a healthy respect . . . Col. H. B. Wright, Hq.,U. S. Strategic Air Forces in Europe, says they are busy delivering bombs to the Germans and whole blood to the Americans, both in adequate quantities. They are also hauling a great number of wounded back from France by airplane. It makes surgery so much easier to have the wounded back in a good hospital four or five hours after they have been wounded. The lack of infections is astonishing . . . Capt. James E. Morgan has been transferred from Resife, Brazil, to an army transport ship which serves our bases in the South Atlantic . . . Maj. James Ockington, with a general dispensary in Southern France, now enjoying life after the excitement of the invasion . . . Capt. A. S. Broglio, located in a beautiful hospital installation in Western England, comfortably removed from London . . . Capt. Wm. C. Humphries, now on limited duty at Oliver General Hospital, Augusta, Ga., after 18 months overseas . . . Capt. Paul Crone, two years at McDill Field, Tampa, Florida, doing pediatrics, but business is slow . . . Major Regis McNamee, formerly at Tampa, transferred in July to Regional Station Hospital, Savannah, Ga. . . . Capt L. Lazarus, at the Station Hospital, Camp Hood, Texas, for about a year on limited duty due to malaria contracted during two years in the South Pacific . . . Maj. George W. Petznick, assistant chief of surgery and chief of orthopedic surgery, Aberdeen Proving Grounds, Aberdeen, Md. . . . Capt. Carl A. Stas, X-ray man with a station hospital out somewhere in the Pacific . . . Capt. G. G. Bassett, with a field hospital in France, met up with Maj. Emil Oberson, another Clevelander . . . Lt. Comdr. James Gray, U. S. Naval Hospital, Paris Island, S. C. for two years. He and another doctor have a family clinic of 1,500 patients a month and plenty to do . . .Capt. Geo. Flynn, writing from the French Alps, lucky —landed on an undefended beach in Southern France, but lost two doctors when the half-track hit a land mine . . . Capt. John H. Budd has been in France since June with a neuro-surgical



"IT'S an ill wind that blows no good," the old proverb declares.

And the genius of medical men is giving new meaning to these old words.

For in the ill wind, the shattering, terrible wind of war, they are finding new facts . . . developing new skills . . . improvising new techniques . . . reaping new knowledge that will play a vast, important part in the building of that "better world to come."



COSTLIER TOBACCOS

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team in an auxiliary surgery group, and has worked in hospitals backing up battles at St. Mere Eglise, Cherbourg, Carenton, St. Lo, La Haye du Puits, etc., in Normandy.

Federal Medical Plan Endorsed By A.P.H.A. Governing Council

The Governing Council of the American Public Health Association on October 4 adopted a report favoring in effect a Federal plan of compulsory health insurance, without consultation with medical and dental leaders of the nation, despite a proposal to do so. This indicates, *The Journal of the American Medical Association* for October 14 declares, the attitude that may be expected of those committed to Federal control of all matters in the health field if they should have control of the Washington bureaucracy that would dominate American medicine should their ideas become effective. *The Journal* says:

"At its annual meeting in New York, October 4, the Governing Council of the American Public Health Association adopted a report favoring in effect a Federal plan of compulsory health insurance. . . . This report, first prepared by a subcommittee, was approved after several amendments by the association's Committee on Administrative Practice. The proposed medical service would be supported by social insurance, supplemented by general taxation, or by general taxation alone.

"The ratification of the report as amended came after extended debate in which there was opposition to the adoption and publication of the report as a stated policy of the association. Those who opposed pointed out (*a*) that the administration of public health in the United States was by no means so universal or so generally adequate that public health departments in general were ready for this step, (*b*) that before the association placed itself publicly on record in the terms of this report there should be consultation with the most interested professional groups, particularly the American Medical Association and the American Dental Association, and (*c*) that the publication of the subcommittee report, its approval by the Committee on Administrative Practice and the call for adoption in the Governing Council occurred within less than thirty days elapsed time, although the subcommittee had been working on the report for a year.

"The motion to adopt the report was made at the October 2 meeting of the Governing Council and was extensively debated at that time. Action was postponed until the October 4 meeting. At that time an amendment was offered to the motion to adopt. This amendment called for the Governing Council to receive this portion of the report of the Committee on Administrative Practice and to refer it to the Executive Board of the American Public Health Association with instructions to confer with the Board of Trustees of the American Medical Association and with the American Dental Association in an attempt to arrive at a statement which these three great professional groups could support. The amendment was lost by a standing vote approximately three to one after a voice vote had left the chair in doubt. The Governing Council then proceeded to vote on a motion to adopt the report; this vote was 49 Aye and 14 No. The opposition to the adoption of the report was led by Drs. Walter A. Bierring, Past President of the American Medical Association, Haven Emerson and W. W. Bauer.

"Now what is the group that adopted this report? Of the 7,493 members of the American Public Health Association 1,571 are Fellows. Only Fellows have a right to vote for governing councilors; the vote is conducted by ballot given to each Fellow when he registers at the meeting; Fellows not in attendance do not have a vote. The Governing Council consists of approximately 100 members, of whom 30 are elected by vote of the Fellows, 10 each year for three-year terms; the rest of the members of the Governing Council hold membership by virtue of being section officers or representatives of affiliated (mostly state) public health associations. Members of the association other than Fellows can vote only on section affairs. The report on compulsory health insurance represents, therefore, the action of the subcommittee which prepared it, the Committee on Administrative Practice which approved it and the 49 members of the Governing Council who voted in its favor. Here is not a democratic practice in action; here is a shrewdly manipulated performance by full-time public officials, economists, bureaucrats. Most of the names of those on the subcommittee are those of men long committed to Federal compulsory sickness insurance and to Federal control of all matters in the health field.

"The American Public Health Association has an obvious right to express itself on any subject related to the public health. The rejection by the majority group of the proposal for consultation with medical and dental leaders indicates the attitude that may be expected of them if they should have control of the Washington bureaucracy that would dominate American medicine should their ideas become effective. Perhaps this step in which these men had leadership will be useful in serving notice once more on the medical, dental, nursing, pharmaceutical and other professional groups as to the nature of the political manipulators in the fields of social security and public health whom the medical professions will be forced to combat."



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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

SPEED THE END OF THE WAR BY BUYING MORE BONDS!

The Sixth War Loan Bond campaign is now in full swing.

Ohio physicians should continue to buy, and buy, and buy. Why? Here are some typical figures on the costs of the war, supplied by the War Department:

It will cost almost as much to fight Japan alone as it did up to now to fight both Germany and Japan. The same amount of freight sent to the Pacific area costs 25 per cent more and it takes twice as many ships to move the same amount of freight. Long range B-29's cost $600,000 each, or twice the cost of the biggest previous bomber. Between D-Day and July 20 we used 61,872,800 gallons of high octane gasoline in the planes that bombed Europe. We should have used many more gallons to reach Japan's target from available bases, and each gallon would have cost thirty cents.

No, the war is not over; neither is it paid for. A steady sale of war loan bonds is imperative. Get yours today.

CINCINNATI CONFERENCE A STEP IN RIGHT DIRECTION

On Sunday, October 29, a four-state gathering of officers and committeemen of the medical associations of Ohio, Indiana, Kentucky and West Virginia was held at the Netherland Plaza Hotel, Cincinnati, under the auspices of the Council on Medical Service and Public Relations of the American Medical Association.

The Cincinnati meeting, arranged by Dr. Edward J. McCormick, Toledo, a member of the Council on Medical Service and Public Relations, was the first of a series of regional meetings to be held by the council for the purpose of informing officers and committeemen of state medical societies about the activities and objectives of the council and for the purpose of receiving suggestions and advice from the "grass roots" of medical organization.

The meeting accomplished a number of worthwhile things, in our opinion, and similar gatherings should be held periodically in all sections of the country.

Those attending were given considerable information by Dr. McCormick, Dr. Joseph Lawrence, director of the Washington office of the A.M.A., Mr. J. W. Holloway, director of the Bureau of Legal Medicine and Legislation of the A.M.A. and acting secretary of the council, and Drs. Bloss, Henderson and Sensenich, members of the Board of Trustees of the A.M.A., about the activities of the A.M.A. in many fields.

It would be safe to assume, we believe, that all who attended left the meeting with a better understanding of the outstanding accomplishments and the aims and policies of the American Medical Association than they had when the meeting opened.

Also, the state society representatives must have had a keener realization of what the A.M.A. can do and can not do; how much the parent organization must depend on the state and local medical societies for cooperation and assistance; how important it is for state and local societies to meet their own responsibilities; how vital it is for state and local societies to take the initiative on matters which are primarily state or local in scope; the bad effects of indifference and apathy on the part of too many members of the medical profession in medical society activities.

On the other hand, we are of the opinion that the officials of the American Medical Association absorbed some information and suggestions which can be put to good use by the A.M.A.

The frank informal discussions which took place revealed that there is a rather general belief among the rank and file of the medical profession that the A.M.A. has not always been as forceful as a large portion of its membership think it should have been; has not always displayed vigorous leadership; has been weak at times in handling its public relations and its relations with its constituent and component societies; has been too slow to act on some occasions; and has been guilty too often of negative, rather than affirmative action.

Those who offered criticism, freely admitted that any errors which could be charged against the A.M.A. were errors of omission rather than errors of commission. While frank, the criticisms were sincere and along constructive lines.

In the final analysis, there is reason to believe that the conference did much to improve the relationship between the A.M.A. on one hand and the four state societies on the other. Weaknesses on the part of all three branches of medical organization—national, state and local—were revealed and suggestions for correcting these weaknesses were presented.

Speaking for the 44 officers and committeemen of the Ohio State Medical Association who were among the 85 physicians who attended, we feel



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"...the most favorable of all disorders for benzedrine therapy."*

In simple depression, Benzedrine Sulfate therapy may be expected to benefit the patient by breaking the strangle-hold of pathologically organized habit-patterns and by restoring what Myerson calls the patient's "energy feeling".

The following instances of simple depression are familiar to every physician:—

1. Depression following acute infectious disease, typically influenza.

2. Depression following surgical operations.

3. Depression following pregnancy and childbirth.

4. Depression accompanying the onset and course of the menopause in women and the involution period in men.

5. Depression associated with menstrual dysfunction.

6. Reactive depression precipitated by an external problem situation which the patient can neither resolve, tolerate, nor ignore.

*Guttmann, E. and Sargant, W.—B. M. J., 1:1013, 1937

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that this innovation was a big step in the right direction. Frequent conferences of this kind will yield additional dividends for it is only through self appraisal and reappraisal that medical organization can find its weak spots and ways of eliminating them.

VETERANS' REHABILITATION: CHALLENGE TO EACH PHYSICIAN!

In the November 4 issue of *The Journal of the American Medical Association* there appeared an article, "The Medical Direction of Human Drives in War and Peace" which, in our opinion, is "must" reading for every physician in the United States.

It is a transcript of an address by Maj. Gen. David N. W. Grant, Surgeon General, United States Air Forces, before the Kentucky State Medical Association and the Wartime Medical Graduate Meeting at Lexington.

Starting off with the statement, "The greatest challenge which faces the medical profession today, in my opinion, is the physical and psychologic rehabilitation of the returning war veteran as a member of his community", General Grant suggests how physicians should go about it to meet this challenge.

Space will not permit extensive abstracting of this stimulating address but permit us to quote the following closing paragraphs:

"As for the rest, we have directed the drives of these war veterans into winning a war and now face the responsibility of redirecting their energies into peace. You may feel that this war veteran is the problem of somebody else—of the psychiatrist, the psychologist, the sociologist. He is, indeed, their problem, but he is everybody's problem—the problem of his government, his community, his employer, his relatives, his friends and his doctor. No one should be better qualified by reason of scientific training and humanitarian interest than the physician to give direction to a national program which will redirect the drives of these men into socially constructive, individually satisfying channels.

"The medical profession, I am convinced, has a profound opportunity stemming from the task of reorienting these men in their group. This is the development of a new type of preventive medicine seeking to improve the individual's health and efficiency by his orientation in an intelligently directed group in which he has the aptitude and desire to work. In this field, which we may for the moment call industrial community medicine, lies the challenge of transplanting to the soil of civilian industry some of the constructive discoveries we have made in the prosecution of a technological war.

"In reality, the family doctor now becomes the specialist, and strangely enough his specialty has already been defined in medical terminology. He is a specialist in orthergasia, which literally means the conditioning of a man to normal function and adjustment."

There in a nut shell is the situation which confronts the medical profession—the individual physician. He—the family doctor of the returning veteran—has an unprecedented opportunity to direct and guide this greatest of all programs of social reconstruction. Much of the job will be one of individual interest and endeavor; one of counselling; one wherein the physician must be teacher, philosopher and friend, as well as physician.

The physician who considers himself too busy or too much of a scientist to play this role as the war veterans return home, seeking advice and encouragement in their efforts to readjust themselves, will be muffing the ball horribly; will be dodging his responsibilities; will be running away from the challenge which confronts his profession.

ARE YOU SATISFIED, LIEUTENANT; AND ARE THE SUBJECTS?

Not long ago some self-appointed prophet predicted that a great number of the approximately 60,000 physicians now serving in the armed forces will be so infatuated with their experiences that they will go all out for governmental medical programs after the war. Also, he predicted that the boys in the ranks will be so satisfied with their treatment at the hands of the Army and Navy medics that they too will want government control of medical care continued.

Maybe so, but we're inclined to trail along with those who feel that the majority of the medics, as well as the majority of the boys in the ranks, will be pretty well fed up with governmental direction by the time they get back home.

However, we think that a lot of them will expect, and demand, a better organization and better distribution of medical personnel and facilities and improved methods of financing the costs of illness, all of which can be accomplished without resorting to governmental programs, except for the indigent and needy handicapped.

We don't know what many of the medical officers who are scattered all over the globe think about this. Maybe they will find food for thought in the following excerpts from remarks made by Dr. Martin H. Fischer, professor of physiology, University of Cincinnati, to the Pi Kappa Epsilon medical fraternity, recently, with 90 per cent of the membership in uniform:

"As medical officers you are already a piece of socialized medicine; and that one hundred per cent. Think about that; and think about what are the subjects of your care. Are you satisfied; and are the subjects; or is either getting out of life's play the best obtainable? Recognize thereafter that your view of medicine is now limited to the acute accident and to the young; and hold in mind that in a little while you will be home again with the chronics and the old. Then compare what is America's medicine—it is the best on earth—with what you may have found in the immediate experience; or in other clime. Whereafter you must make up your own minds whether America's history in medi-

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cine shall continue as is, or be handed over in ever-increasing fraction to a starry-eyed group of Sunday school idealists backed by the economic sceneries painted of dictators, state socialists and communists. And don't think that I am calling names; I am using these words in scientific designation of what is government intent in U.S.A.; an intent now concealed in the blah-blah of rights, freedoms and securities.

"If you think of your careers in the terms of weeks or months, none of you need worry. The aspiring farmer lad willing to work his hands off to enter college and thereafter to work his head off to become a doctor, has become an anachronism. All you must do is register—and the government provides. If you are in the Army, it will look after you; and if in the Navy, it will do likewise. My advice to you, especially if you have not learned what is meant by the sterling qualities of the old doctor, is to sit tight. It will bear you through a holocaust. But I believe that before many years pass you will be driven to look upon a wider landscape. The future, as always, gives the young a choice between what is easy and the hard. Then it is that there will be tested what is your soul. And your soul, Gentlemen, is the only thing on earth or in heaven, that's **yours**!"

WHY CONFINE SUCH INSTRUCTION TO STUDENTS?

According to the *Cleveland News*, Western Reserve University School of Medicine is presenting a course in bedside manners to its third-year students. The course will suggest to the student how to talk to patients and to the public on medical questions. A spokesman for the school states:

"At the bedside the patient should be given a clear picture of his illness. The physician's words should be selected carefully so that the patient and his family will not be alarmed unnecessarily. The patient has a right to know what is happening to him and the good doctor provides this information adequately. In serving as a health teacher for his community through speaking engagements, the radio and the printed word, the doctor should know the technique of putting his message across. He can not use the same language he would use among his colleagues or in the medical school classroom."

The idea has merit, both for the student and the physician now in practice. Also, if we may add our own two-bits worth, we'd like to see more medical schools provide more "must" courses for wising up students about some of the medical and social questions which confront the physician in practice and an intensive course in medical ethics.

Sure, we know its done in some schools—maybe all of them—but how well? Of course, experience is a great teacher but more basic instruction on these questions would be mighty valuable knowledge for the youngster when he hangs out his shingle.

Come to think of it, it wouldn't be a bad idea for medical societies to run a few "refresher" courses for their members on the social and ethical phases of the practice of medicine. Students are not the only ones who should be exposed to advice and suggestions about the proper physician-patient relationship and the social aspects of medicine.

CLEVELAND MEDICAL LIBRARY A LIVING, USEFUL MONUMENT

On November 26 and 27 the Cleveland Medical Library Association celebrated its fiftieth anniversary. This event calls for congratulations and an expression of commendation from *The Ohio State Medical Journal.*

Cleveland and Ohio are fortunate in having one of the finest medical libraries in the world. Many times in answering inquiries from physicians for reference material we have suggested that they get in touch with the Cleveland Medical Library, realizing that its well-stocked shelves would provide medical literature on most any medical question or problem.

Those who have steered the course of the Cleveland Medical Library during the past 50 years are to be commended for their initiative and foresight. They have helped to erect a monument—a living, useful monument—which has meant much to the physicians of Northwestern Ohio, especially, and has added much to the progress and prestige of medicine in Ohio, generally.

TALK TO YOUR LEGISLATOR ON THIS QUESTION!

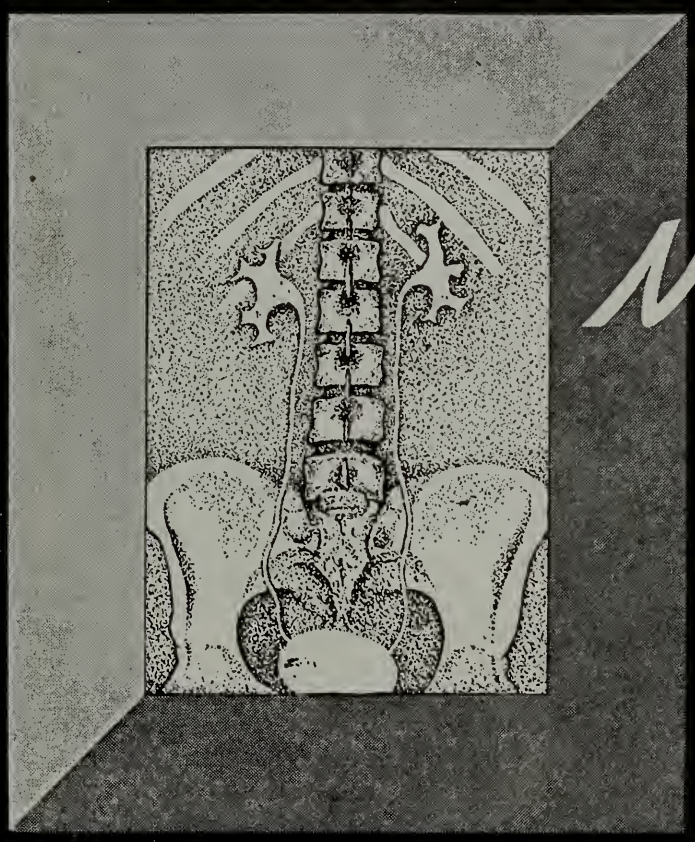
A special salary study commission of the Ohio General Assembly has submitted a report to Governor Bricker recommending pay increases for state employes of all classes.

It will be recalled that at the 1944 Annual Meeting of the Ohio State Medical Association the House of Delegates adopted a resolution favoring salary increases for state employes who must possess professional, scientific and technical education and training, notably physicians, attorneys, engineers, nurses, technicians and those holding important administrative positions.

If the Association's action is to amount to anything, physicians will have to discuss the matter with members of the General Assembly and point out that the medical profession is in favor of the principle of adjusting upward the salaries of deserving state employes.

Action by individual physicians immediately is suggested so the Legislature will know the sentiment of the medical profession when the question is considered.

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FOR VICTORY AND AFTER: BUY WAR BONDS

In Memoriam

Albert A. Brooks, M. D., Orrville; Cleveland University of Medicine and Surgery, 1892; aged 86; died Oct. 24. Dr. Brooks retired a few years ago after practicing in Orrville for 60 years. His widow and a son survive.

Andrew Roscoe Carrigan, M. D., Manchester; Kentucky School of Medicine, Louisville, 1903; aged 64; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Oct. 16. A former president of the Adams County Medical Society, Dr. Carrigan first practiced in Sardis, Ky., moving to Manchester in 1917. After 12 years there, he located in Maysville, Ky., returning to Manchester in 1932. He had been in ill health for the past two years. Dr. Carrigan was a member of the Masonic Order and the Presbyterian Church. His widow and three sons survive.

Edward Ellison Coburn, M. D., Columbus; Starling Medical College, Columbus, 1894; aged 77; died Nov. 5. Dr. Coburn practiced in Columbus for 25 years. Surviving are his widow, a son and a sister.

Clark Barrows Hatch, M. D., Newark; Ohio Medical University, Columbus, 1904; aged 65; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American Academy of Ophthalmology and Oto-Laryngology; died Oct. 21. After two years of postgraduate training, Dr. Hatch began the practice of medicine in Newark in 1906. His grandfather and his father had preceded him in practice there. During the First World War, Dr. Hatch was an examiner for the local draft board and was active in the various local war drives. He was a director of the Y.M.C.A. for several years and had been chairman of the Board of Trustees of the Second Presbyterian Church. Dr. Hatch was one of the organizers and a past president of the Rotary Club, a member of the Masonic order and Phi Gamma Delta, Alpha Kappa Kappa and Theta Nu Epsilon fraternities. Two daughters survive.

William Cephas Herman, M. D., Cincinnati; Miami Medical College, Cincinnati, 1902; aged 71; member of the Ohio State Medical Association and the American Medical Association; died Oct. 24. Nationally known ornithologist, Dr. Herman practiced in Cincinnati for over 40 years. His widow and two brothers survive.

George P. Huddle, M. D., Stoutsville; Starling Medical College, Columbus, 1888; aged 82; died Oct. 20. Dr. Huddle practiced in Stoutsville and Fairfield County for 55 years. He was a member of the Reformed Church. Surviving are his widow, a daughter and two sons.

Charles Robert Lewis, M. D., Akron; Ohio State University College of Medicine, 1916; aged 62; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Nov. 6. A member of the staff of People's Hospital, Dr. Lewis was a leader in Negro circles in Akron for 28 years. He was a member of the Masonic Order and the Baptist Church. His widow and a brother survive.

Ira Newton Martin, M. D., Portsmouth; Eclectic Medical College, Cincinnati, 1902; aged 72; former member of the Ohio State Medical Association and the American Medical Association; died Oct. 23. Many years in practice in Portsmouth, Dr. Martin had been an invalid for 15 years. Surviving are his widow, a son, his brother—Dr. A. B. Martin, Blanchester, and two sisters.

Arnold Peskind, M. D., Cleveland; University of Wooster, Medical Department, Cleveland, 1887; aged 82; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Oct. 30. An active practitioner in Cleveland for 57 years, Dr. Peskind was a native of Russia, settling in this country in 1882. His widow survives.

Herbert Emerson Smead, M. D., Toledo; Western Reserve University School of Medicine, 1897; aged 71; former member of the Ohio State Medical Association and the American Medical Association; died Oct. 21. A former president of the Toledo Academy of Medicine, Dr. Smead retired eight years ago because of ill health. He had been chief of staff of Toledo Hospital. Dr. Smead was a Mason. Surviving are a daughter, a son, a sister, and two brothers, one of whom is Dr. Lewis F. Smead, Toledo.

Frank Clinton Smith, M. D., Geneva; Hahnemann Medical College and Hospital, Chicago, 1893; aged 77; member of the Ohio State Medical Association and the American Medical Association; died Oct. 9. Dr. Smith practiced in Geneva and surrounding communities in Ashtabula County for nearly 50 years. He was a member of the Masonic Order, Rotary Club, and the Modern Woodmen of America.

Thomas Grant Youmans, M. D., Columbus; Starling Medical College, 1895; aged 75; died Oct. 18. A former police surgeon for Columbus, Dr. Youmans taught dermatology at Ohio Medical University for several years, and was a former member of the staff of the old Protestant Hospital and Woman's Hospital. He was a member of the Masonic Lodge. A sister survives.



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Licenses to Practice in Ohio Issued to 257 Medical School Graduates at Recent Board Meeting

LICENSES to practice medicine and surgery in Ohio were granted 257 graduates of approved medical schools, who had passed the September examinations, at a meeting of the State Medical Board in Columbus, November 14.

Nine recent graduates of osteopathic schools received certificates to practice osteopathic medicine and surgery. In addition, 64 osteopaths, previously licensed to practice osteopathy and surgery in Ohio, met additional requirements and were successful in special examinations entitling them to certificates to practice osteopathic medicine and surgery.

The Board also granted certificates in their respective limited branches to 6 mechanotherapists; 1 chiropractor, 4 chiropodists, 10 masseurs and 5 cosmetic-therapists.

Dr. Earl R. Haynes, Newark, a graduate of the Ohio State University College of Medicine, made the highest grade, 87.7 per cent, in the medical examinations. Dr. Harry M. Berley, Yellow Springs, a graduate of Northwestern University Medical School, was second with 87.5 per cent. Third place went to Dr. Jerome R. Berman, Cincinnati, a graduate of the University of Cincinnati College of Medicine, whose grade was 87.3 per cent.

The following doctors of medicine were granted licenses:

OHIO STATE UNIVERSITY COLLEGE OF MEDICINE—Joseph W. Allman, Columbus; Harold V. Beighley, Struthers; Louis A. Black, Los Angeles, Calif.; William H. Bond, Cleveland; Arthur M. Call, Columbus; Irving H. Canfield, Columbus; Rudolf H. Caplan, Dayton; Harold Carter, Columbus; Charles A. Clifton, Columbus; George D. Clouse, Columbus; Bennett P. Cohen, Pittsburgh, Pa.; Ernest S. Crouch, Columbus; Richard C. Curlis, Cincinnati; Charles F. Curtiss, Dennison.

William D. Dewar, Pensacola, Fla.; Richard E. Dustin, Columbus; Thomas K. Ellis, Massillon; Richard D. Fishell, Fort Worth, Texas; Robert P. Fosnaugh, Columbus; Thomas C. Frell, Warren; Richard L. Fulton, Dayton; Maurice E. Galante, New York City; James T. Gilboy, Jr., Youngstown; Lawrence I. Goldberg, Washington, D.C.; William L. Grover, Bainbridge, Md.; Herman L. Guyselman, Springfield.

Earl R. Haynes, Newark; Rowland J. Helman, San Diego, Calif.; James L. Henry, Columbus; Edward A. Hill, Brewster; Ernest Hoffman, Jr., Findlay; John C. Holliday, Columbus; Victor H. Holliger, Toledo; Robert B. Hosier, Columbus; Henry G. Hughes, Columbus; Hugh B. Hull, Jr., Greenfield; George P. Hummel, Columbus; Carl J. Ide, Bowling Green; Richard L. Johnson, Lima; Eli Kamellin, Cleveland; Victor E. Kaufman, Columbus; Sidney A. Kay, Akron; Charles L. Keagy, Canton; Paul Kirch, Columbus; Joseph R. Kreischer, Convoy; Sidney Krohn, Cleveland.

Paul E. Longaker, Conneaut; Donald W. K. Martin, New York City; John W. Moberly, Lexington, Ky.; Robert B. Morrison, Jr., Zanesville; Wilford B. Neptune, Columbus; Alexander P. Orfirer, Cleveland; Francis J. Owens, Youngstown; Robert E. Pickett, Columbus; Harold A. Poneman, Toledo; Guy E. Rader, Columbus; Martyn C. Raupple, Youngstown; Manuel J. Rosen, Cleveland; Morton Rosenthal, Cleveland Heights; Elinor A. Rossbach, Columbus; George R. Schneider, Cleveland; Edward A. Sprague, Athens; Carter R. Straub, Columbus.

Charles O. Townley, Columbus; Raoul W. Urich, Elyria; Zana Jones-Dietz Vaile, Columbus; Dean C. Varney, French Camp, Calif.; Robert A. Vogel, Columbus; Donald R. Wenner, Upper Sandusky; Paul R. Zaugg, Canton.

UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE—William N. Adkins, Dayton; Bernard W. Albers, Cincinnati; John E. Allen, Cincinnati; Weldon C. Bembower, Rochester, N.Y.; George M. Benko, Perth Amboy, N.J.; Abner Berkwits, Brooklyn, N.Y.; Jerome R. Berman, Cincinnati; John T. Bickmore, Cincinnati; Foster Boyd, Jr., Cincinnati; Albert A. Brust, Jr., Cincinnati; Donald L. Burhans, Peoria, Ill.; John W. Burke, Lima; Wilson J. Buvinger, Jr., Cincinnati.

Louis R. Chaboudy, Portsmouth; Robert H. Cofield, Newtown; George A. Curry, White Sulphur Springs, W. Va.; George C. Dix, Cleveland; Robert K. Dodge, Milwaukee, Wis.; R. Moore Dodrill, Jr., Welch, W. Va.; Alvin L. Dunbar, Cincinnati; William G. Echman, Jr., Fort Mitchell, Ky.; Virginia M. Esselborn, Cleveland; Russell L. Fankhouser, Pine Grove, W. Va.; Albert J. Farrell, Jr., Cincinnati; Walter E. Fening, Hamilton; Alfred Flarsheim, Boston, Mass.; Peter A. Fomenko, Cincinnati.

John P. Garvin, Columbus; Walter D. Griest, Cincinnati; Lawrence T. Hiltz, Covington, Ky.; James T. Howell, Detroit, Mich.; Harry C. Hudson, Cincinnati; Walter G. Hunsberger, Newark; Harry J. Jacobs, Los Angeles, Calif.; C. Kohlsteadt, New Augusta, Ind.; William K. Lehmann, Cincinnati; Joseph Levine, Cincinnati; Joseph E. Levinson, Cincinnati; Francis C. Link, Springfield; Thomas N. Lococo, Milwaukee, Wis.; Robert J. McCabe, Cincinnati; George E. McCoy, Galveston, Texas.

Bernard S. Matthews, Cleveland; Arthur W. Nadler, Cincinnati; Alvin Nathan, Cincinnati; Henry E. Nelson, Madison, Wis.; David W. Nielsen, Detroit, Mich.; John G. O'Brien, Brooklyn, N.Y.; George Parker, Indianapolis, Ind.; Charles E. Rankin, Lexington, Ky.; William A. Remley, Kansas City, Mo.; Samuel E. Reynolds, Morehead, Ky.; Howard E. Rothring, Cincinnati; Robt. A. Rydze, Pittsburgh, Pa.

Marshall D. Schechter, Milwaukee, Wis.; Jane B. Schieve, Cincinnati; Harold N. Schwinger, Brooklyn, N.Y.; Vincent J. Seiwert, Cincinnati; John E. Sharts, Jr., Indianapolis, Ind.; William E. Shaw, Cincinnati; Francis J. Slavin, Howell, Mich.; Byron E. Swainey, Cincinnati; Kazuo Tashiro, Cincinnati; Kiyoshi Tashiro, Cincinnati; Adrian C. Twinem, Steubenville; Charles W. Vogl, Chicago, Ill.; Hugh B. Walker, Clinton, Mo.; Robert W. Weber, Marion; Raymond E. Weigel,



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Donald H. Chickering, Detroit, Mich.; Ernest E. Clark, Cleveland Heights; Thomas W. Cook, Cleveland; Harvey J. Dworken, Cleveland; Jerome A. Eiker, Cleveland; Paul G. Ecker, Cleveland Heights; Francis E. Elliott, Mansfield; Richard A. Elmer, Cleveland; Martin Epstein, Cleveland; Marvin W. Evans, Wooster; Raymond N. Ferreri, Connersville, Ind.; Ruth M. Finzer, Brooklyn, N.Y.; Robert I. Firestone, Cleveland; Harold C. Franley, Cleveland; Philip G. Fulstow, Norwalk.

William F. Gibbons, Cleveland; Alice A. Hand, Cleveland Heights; Dale E. Hart, Massillon; Patrick F. Healey, Cleveland; Arnold L. Heller, Cleveland; Willard M. Holden, Akron; Frank S. Houser, Cleveland; Owen F. Hughes, Cleveland; Kenneth A. Huizenga, Chicago, Ill.; Robert L. Hunt, Akron; Leonard J. Janchar, Cleveland; Anthony P. Jerome, Beaver Falls, Pa.; David C. Jones, Cleveland; Betty J. Killin, Cleveland; Philip C. Leavenworth, South Euclid; John P. Lenahan, Iowa City, Iowa; Francis M. Lenhart, Defiance; Vern L. Lester, Detroit, Mich; Robert C. Little, Grosse Point, Mich.

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GRADUATES OF OUT-OF-STATE SCHOOLS—Martin Hirsch, Cleveland, Friedrich Wilhelm University, Breslau, Germany; Athanasium M. Barkouis, Cleveland, National University of Athens, Greece; Evelyn Marie Stein, Cleveland, Royal Elizabethan University of Hungary, Pecs, Hungary; David M. Gerber, Middletown, Cornell University, New York, N. Y.; James A. McMurrin, Cincinnati, William A. Ballas, Pittsburgh, Pa.; Alphonse L. Bax, Cleveland, Frederick G. Hamilton, East Cleveland, Myron C. Hanysh, Camp Cooke, Calif., Edward T. Juler, Cincinnati, Emil W. Mozola, East Cleveland, Leo H. Simoson, Luzerne, Pa.; Jack L. Whitaker, Cleveland Heights, Albert E. White, East Cleveland, Eugene N. Wright, East Cleveland, Hahnemann Medical College, Philadelphia.

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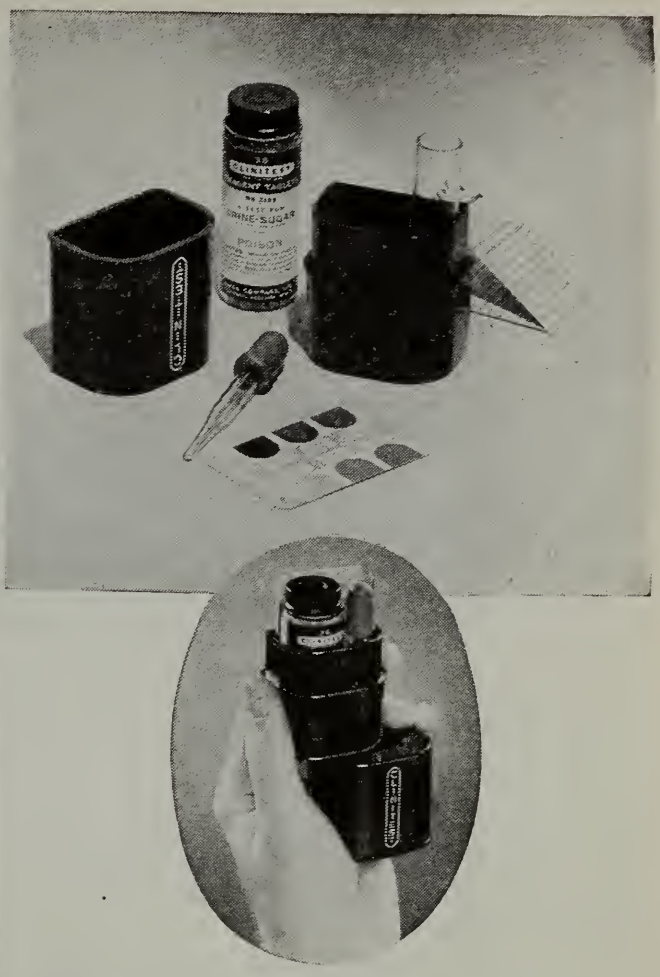
University, Washington, D.C.; John C. Kelleher, Lorain, Charles Lee Liggett, St. Clairsville, Arthur B. Van Gundy, Columbus, Jefferson Medical College, Philadelphia; Catherine C. Geiger, Toledo, William T. Sweeny, Cleveland, Loyola University, Chicago, Ill.; Harry M. Berley, Yellow Springs, Donald B. Cuthbertson, Toledo, Robt. M. Gluckman, Chicago, Ill., John E. Harroun, Toledo, William T. Swartz, Cincinnati, Northwestern University, Chicago, Ill.; Juliette N. Eliscu, Cincinnati, Paul H. Harmon, Sayre, Pa., Rush Medical College, Chicago, Ill.; Arthur T. Evans, Cincinnati, Richard D. Simon, Toledo, University of Chicago, Chicago, Ill.; Thomas T. Carroll, Toledo, University of Illinois, Chicago, Ill.; Travis J. Towson, Cleveland, University of Oregon, Portland; Arthur B. Shaul, Jr., Cleveland, Alex. M. Rosenblum, Youngstown, University of Pennsylvania, Philadelphia; William H. Miller, Jr., Vermilion, University of Pittsburgh, Pittsburgh; Harold C. Messenger, Jr., Xenia, Margaret B. Shipley, Canton, University of Rochester, Rochester, N.Y.; Gordon T. Bowen, Akron, University of Southern California, Los Angeles; Cloice H. Biggins, Toledo, College of Medical Evangelists, Los Angeles; Leonard W. Schrank, Akron, University of Wisconsin, Madison; Marie E. Russell, Cleveland, Woman's Medical College of Pa., Philadelphia; Joseph M. Hester, Rochester, Bowman Gray Medical School of Wake Forest College, Winston-Salem, N.C.

Dr. Mark Addresses Medical Groups

Dr. Louis Mark, Columbus, spoke on "The Role of the Chest Specialist in the Control of Tuberculosis", at a recent meeting sponsored by Colorado members of the American College of Chest Physicians, at Denver. He also addressed a meeting of the clinical society of the Jewish Consumptive Relief Society at Denver. Other recent addresses by Dr. Mark include appearances before the Stark County Medical Society at Massillon, and the Southern Medical Association at St. Louis. Dr. Mark is a member of the Executive Council of the American College of Chest Physicians and Regent for Ohio, Michigan and West Virginia.

Red Cross Denies Rumors

A categorial denial of rumors that Red Cross blood plasma is being sold to the armed forces has been issued by Red Cross Chairman Basil O'Connor, who said: "These rumors are vicious lies and apparently circulated by persons who wish to deprive our fighting men of life-saving plasma. The blood which more than 100,000 patriotic Americans donate each week to the Red Cross is turned over to the Army and Navy and processed by them into blood plasma, or flown as refrigerated whole blood to Europe and the Pacific. Full possession and control of the blood passes into the hands of the Army and Navy when the Red Cross ships it from its donor centers to processing laboratories. The Army and Navy, as is well known, administer this blood or plasma to wounded soldiers and sailors without any charge."



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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M. D., CINCINNATI)

BUTLER

A combined dinner meeting of the Union District Medical Association, Butler County Medical Society and the Woman's Auxiliary was held at the Anthony Wayne Hotel, Hamilton, October 25. Dr. Ralph W. Eddy, Cincinnati, spoke on "The Management of Relaxations of the Uterine Supports". Mrs. Cleo Dawson Smith gave a dramatic review of the current Broadway play, 'Tomorrow The World".—Azel Ames, M.D., president.

HAMILTON

The Academy of Medicine of Cincinnati presented the following programs during November:

Nov. 7—"Surgical Treatment of Pulmonary Suppuration", Dr. Herbert C. Maier, instructor in surgery, Columbia University, New York, N. Y.

Nov. 21—"The Early Diagnosis of Cancer", Dr. Shields Warren, assistant professor of pathology, Harvard Medical School, Boston, Mass. This meeting was under the joint auspices of the Cancer Control Council and the Academy of Medicine—Bulletin.

HIGHLAND

"Decompensating Heart Disease", was the topic discussed by Dr. Donald L. Mahanna, Columbus, at a meeting of the Highland County Medical Society, Nov. 1, at the Hotel Parker, Hillsboro.—News clipping.

Second District

(COUNCILOR: H. C. MESSENGER, M. D., XENIA)

GREENE

The Greene County Medical Society, paying tribute to four of its members who have each practiced medicine more than 50 years, honored the physicians with a recognition dinner, October 12, at the Antioch Tea Room, Yellow Springs. The veteran physicians are: Dr. W. C. Marshall, Yellow Springs, former Greene County health commissioner; Dr. A. D. DeHaven, Xenia, former city health commissioner; Dr. C. E. Ream, Bowersville, and Dr. C. W. Miller, Osborn. The principal speaker at the testimonial banquet was Dr. E. Arn, Dayton, who discussed "Changes in the Medical Profession Between Then and Now". Short talks were given by the guests of honor.—News clipping.

MIAMI

Dr. C. C. Higgins, Cleveland, gave an illustrated talk on "Present-Day Management of Infections of the Urinary Tract", at a meeting of the Miami County Medical Society, November 3, at the Piqua Memorial Hospital, Piqua. A number of physicians from Darke, Shelby and Champaign counties were guests at the meeting. —G. A. Woodhouse, M. D., secretary.

MONTGOMERY

"Federalization of Medicine", was the topic discussed by Hon. Harry P. Jeffrey, member of Congress for the Third District, at a meeting of the Montgomery County Medical Society, November 3, at Miami Valley Hospital. The program also included the showing of a film entitled "Asphyxia Neonatorum".—C. D. Padan, M. D., secretary.

Fourth District

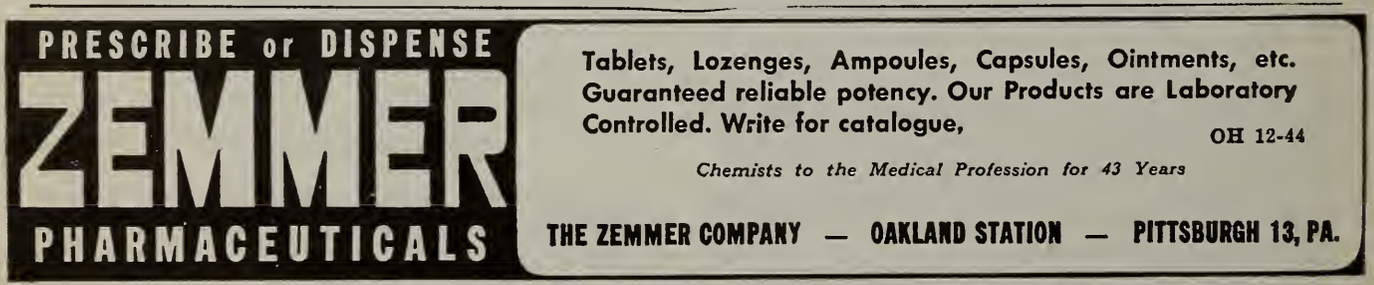
(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

LUCAS

The Academy of Medicine of Toledo presented the following programs during November.

Nov. 3—Eleventh Annual Postgraduate Day of the Medical Institute of The University of Toledo. Speakers: Lt. Col. Joseph C. Bell, M. C., Perry Jones Hospital, Battle Creek, Mich.; Col. B. R. Kirklin, M. C., chief consulting roentgenologist, Office of the Surgeon General, U. S. Army,





Washington, D. C.; Dr. U. V. Portmann, Cleveland Clinic.

Nov. 10—Section of Pathology, Experimental Medicine and Bacteriology. "Molds in Allergy—A Decade of Progress in Etiology of Allergic Diseases", Dr. Samuel M. Feinberg, associate professor of medicine and chief, Division of Allergy, Northwestern University Medical School, Chicago, Ill.

Nov. 17—Medical Section. Symposium—"Some Frequent Complaints in Infancy and Childhood"—Dr. L. I. Clark, "Poor Appetite"; Dr. Berman Dunham, "Colds"; Dr. H. M. Foster, "Colic".—Bulletin.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

CUYAHOGA

Dr. Herman L. Kretschmer, clinical professor of genito-urinary surgery, University of Illinois College of Medicine, Chicago, and President-Elect of the American Medical Association, was the guest speaker for the Annual Lower Lecture of the Cleveland Academy of Medicine, November 24. His subject was "Present Status of the Prostatic Problem".

The following program was presented by the Industrial Medicine and Orthopedic Section of the Academy, November 15: "Traumatic Venous Thrombosis of the Leg and Pulmonary Embolism", Dr. L. N. Atlas; "Problem Fractures of Forearm and Shoulder", Dr. A. W. Tramer; "Cardiac Patient In Industry", Dr M. L. Siegel; "Injuries of the Chest", Dr. S. O. Freedlander; "Disorganizing Fractured Knee Joint and Treatment", Dr. R. S. Reich.—Bulletin.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

PORTAGE

Dr. C. C. Higgins, Cleveland, spoke on "Management of the Urinary Calculi", at a meeting of the Portage County Medical Society, November 9, at the Robinson Memorial Hospital, Ravenna.—Emily Widdecombe, M. D., secretary.

SUMMIT

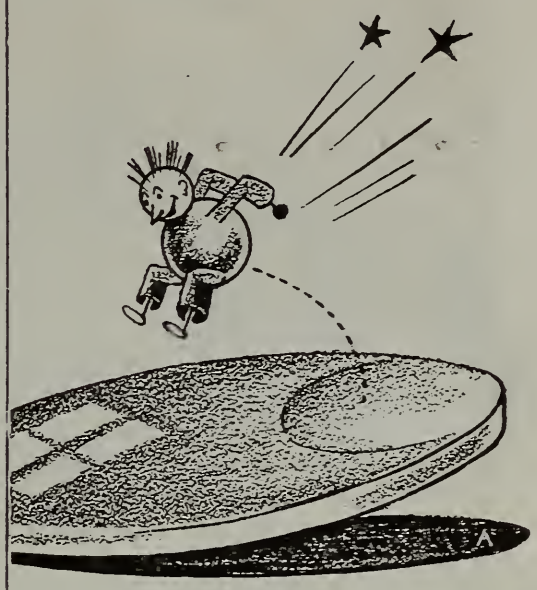
"Re-evaluation of the Problem of Tropical Diseases", was the topic discussed by Dr. G. L. Dunnahoo, chief, Foreign Quarantine Division, United States Public Health Service, Washington, D. C., at a meeting of the Summit County Medical Society, November 7, at City Hospital, Akron.—Bulletin.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

ATHENS

At a meeting of the Athens County Medical Society, October 12, in the Presbyterian Church, Nelsonville, Dr. H. H. Fockler presented a case report and Dr. J. R. Sprague discussed the use



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of penicillin. Capt. John T. Sprague, a former member of the society, told of some of his Army experiences.—News clipping.

LICKING

Dr. Dwight M. Palmer, Columbus, acting secretary of the Ohio State University College of Medicine, addressed the Licking County Medical Society, Nov. 2, at the Granville Inn, Granville, on "Medical Education, Today and Tomorrow".—News clipping

WASHINGTON

A program on "Industrial Health" was presented at a dinner meeting of the Washington County Medical Society and the Industrial Division of the Marietta Chamber of Commerce, Nov. 8, at Marietta, with approximately 25 persons present. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, spoke on "The Industrial Health Program of the Ohio State Medical Association", and Dr. Christopher Leggo, chief, Bureau of Industrial Hygiene, State Department of Health, discussed "Medical Service in Industry". The meeting concluded with a question-and-answer session.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

SCIOTO

At a joint meeting with members of the pharmaceutical, dental and nursing professions, members of the Hempstead Academy of Medicine enjoyed a film upon "Nutrition", Nov. 13, at Portsmouth. The picture, in technicolor, considered the relations which are always between nutritional disorders and other disease entities.—T. W. Frame, M.D., secretary.

Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

FRANKLIN

The Columbus Academy of Medicine presented the following programs during November:

Nov. 6—"Recent Developments in the Diagnosis and Treatment of Hemorrhagic Diseases", Dr. Armand J. Quick, associate professor of pharmacology, Marquette University School of Medicine, Milwaukee.

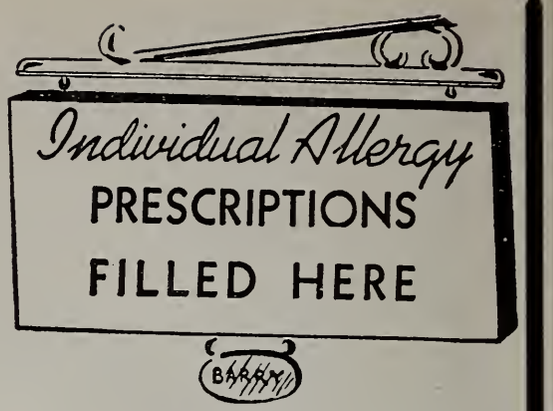
Nov. 20—"Progress in Surgery—The 1944 Review", Dr. Wm. P. Smith, Columbus.—Bulletin.

ROSS

The Ross County Academy of Medicine, Chillicothe, adopted the following resolution in tribute to the late Dr. Carl A. Hyer, Columbus:

"Be It Resolved by the Ross County Academy of Medicine that in the death of Dr. Carl A. Hyer, Columbus physician for more than 20 years, the profession has lost a most valued member.

"And be it stated that on October 5, 1944,



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which date was eight days before his death, Dr. Hyer did give a masterful address before the Academy upon the subject: "Cirrhosis of the Liver", from the suffering of which disease Dr. Hyer did much to relieve mankind.

"And be it further resolved that a copy of this resolution be sent to his son, David; that a copy be sent the secretary of the Columbus Academy of Medicine for reading before that Academy; that a copy be sent to the Editor of *The Ohio State Medical Journal* for entry upon the pages of that Journal".—Ralph W. Holmes, M.D., secretary.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M. D., SANDUSKY)

LORAIN

Dr. Bernard H. Nichols, Cleveland, spoke on "The Diagnosis of Bone Sarcoma", at a meeting of the Lorain County Medical Society, November 14, at the Lorain County Club. Dr. Valloyd Adair gave an address in tribute to the late Dr. David Thomas.—L. H. Trufant, M. D., secretary.

WOMAN'S AUXILIARY NEWS

(By MRS. FRED W. BROSIUS, MIDDLETOWN)
Chairman, Publicity Committee

BUTLER

The members of the Butler County Medical Society and the Union District Medical Association acclaimed the joint dinner meeting with the Woman's Auxiliary, October 25, one of the outstanding events of the season. Guest speaker was Cleo Dawson, noted dramatist, who gave a superb performance of "Tomorrow the World". Preceding dinner, a brief business session was conducted by Mrs. Harry Burdsall, president. Thirty members answered to roll call. Three new members were welcomed by the president. The members voted to replenish the treasury, by each member bringing "white elephants" to be auctioned off at the December meeting. Mrs. James Hartman, Cincinnati, Commander of District One, Women's Field Army for the Control of Cancer, talked briefly regarding the need for the cooperation of the Woman's Auxiliary in this vital work. Hostesses for the meeting were: Mrs. Azel Ames, Mrs. J. A. Mackie, Mrs. E. T. Keating, Mrs. Vernon Roden, Mrs. Louis Frechtling, Mrs. George Flenner, and Mrs. Malcolm Cook.

KNOX

Mrs. Charles Baldwin of Centerburg, Ohio, opened her home to the Woman's Auxiliary of the Knox County Medical Society, Wednesday evening, November 1. Mrs. John Drake, president, conducted a brief business meeting. Mrs. Julius Shamansky, Mrs. James Lee, and Mrs. J. M. Pumphrey were appointed to organize circles to sew for local hospitals. At the conclu-



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sion of the meeting, contest prizes were awarded to Mrs. Shamansky and Mrs. Pumphrey. Refreshments were served at a beautifully appointed table. December 6 is the date of the next meeting, at the home of Mrs. Julius Shamansky, with Mrs. Richard Gomer as assistant hostess.

MAHONING

The first meeting of the season of the Woman's Auxiliary to the Mahoning County Medical Society was held October 16, at Youngstown. A report of the doctors in service was given by Mrs. B. Bowman and Mrs. J. K. Herald. Chairmen of the various committees presented their reports. A very interesting meeting has been planned for December 8. Dr. Frank F. Tallman, Commissioner of Mental Diseases for the State of Ohio, will talk on "Community Program for Mental Health". Members of the Auxiliary were hostesses at a U.S.O. party for the men in the service, on November 26.

MARION

A luncheon meeting of the Woman's Auxiliary to the Marion Academy of Medicine was held Saturday, October 28, at the Hotel Harding. Mrs. J. B. Taylor was acting hostess. Dr. T. H. Sutherland gave an interesting talk on "Aviation Medicine as a Specialty". During a brief business meeting a contribution of $5.00 was made to the Marion County War Chest campaign. New members welcomed were Mrs. F. C. Smith, Mrs. P. W. Smith and Mrs. K. H. Feistkorn. A report on the style show and benefit bridge was given by Mrs. Fillmore Young.

ROSS

The Woman's Auxiliary to the Ross County Academy of Medicine met at Chillicothe, Thursday evening, November 2, for their monthly dinner meeting. Mrs. Ralph W. Holmes presided in the absence of the president, Mrs. Walter Breth. Thirteen members were present. Miss Elizabeth Kellhofer, guest speaker, reviewed the history of the U.S.O. and told of the interesting work being done by that organization.

SENECA

Mrs. Robert Chamberlain entertained the members of the Woman's Auxiliary to the Seneca County Medical Society, Tuesday evening, October 17, at her home in Tiffin. Mrs. Eva Gibbon and Mrs. George Williard were assistant hostesses. Mrs. Edmund Ley presided at the brief business session. Members worked on Red Cross Kits and were served a delicious lunch at the close of the meeting.

WASHINGTON

On Wednesday evening, October 10, the Woman's Auxiliary to the Washington County Medical Society enjoyed a dinner meeting at the Betsey Mills Club, Marietta. Mrs. J. F. Weber acted as hostess. A brief business session was conducted by Mrs. Richard Sloan. Mrs. William Ludwig, a teacher of medicine and nursing in Peking, China, for seven years, gave an interesting and informative talk. Mrs. Ludwig was sent to China by the Rockefeller Foundation. Members of the Auxiliary are doing splendid work by taking charge of the packing for the Red Cross. Mrs. W. S. Hawn will be hostess for the dinner meeting in November.

News Notes

Cleveland—"Medical Treatment of Hyperthyroidism", was the subject of an address made by Dr. Edwin B. Astwood, assistant professor of pharmacology, Harvard Medical School, under the auspices of the Frank E. Bunts Institute, Nov. 8, at the Cleveland Clinic.

Columbus—Dr. C. C. Sherburne, Past-President of the Ohio State Medical Association, spoke on "Socialized Medicine", at a meeting of the Cooperative Club.

Cincinnati—The following officers of the Bethesda Hospital staff have re-elected: Dr. William J. Graf, president; Dr. Elmore A. Kindel, vice-president; and Dr. Braden M. Alleman, secretary.

Columbus—Dr. E. J. Stedem spoke on "Cancer Research" at a public meeting held in Delaware under the auspices of Gamma Mu chapter of Beta Sigma Phi sorority.

Mt. Vernon—"Newer Concepts in the Treatment of Tuberculosis", was the title of a lecture made by Dr. Karl Klassen, Columbus, at a meeting of the District Nurses' Association.

Circleville—Dr. B. L. Chipley, superintendent of the Mt. Logan Sanitarium, Chillicothe, spoke on "Diseases of the Chest", at a meeting of the Rotary Club.

Huron—Dr. C. E. Swanbeck, president of the Erie County Medical Society, and Dr. F. N. Nahla, Erie County health commissioner, led discussion at a meeting on cancer control sponsored by the Ohio Division, Field Army for the Control of Cancer.

Toledo—A program of effective control for tuberculosis was outlined for members of the local Parent-Teachers Association at a meeting in the Toledo Academy of Medicine building, addressed by Dr. Howard Holmes, recently appointed a member of the Ohio Public Health Council. Dr. Walter Hartung, city health commissioner, participated in the discussion.

Cleveland—The weekly radio program sponsored by the Cleveland Health Museum, in cooperation with the Cleveland Academy of Medicine and the Cleveland Dental Society, has been resumed by station WGAR. It occurs each Tuesday from 4:30 to 4:45. Speakers in November included: Dr. M. Lambright, Dr. Lester J. Taylor and Dr. Charles E. Kinney.

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